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AQCESS IS A MICROCOMPUTER BASED, INTEGRATED, TERMINAL ORIENTED, INTERACTIVE, ON-LINE COMPUTER SYSTEM DESIGNED TO SUPPORT PATIENT ADMINISTRATION, CLINICAL RECORDS AND QUALITY OF CARE EVALUATION FUNCTIONS WITHIN A MILITARY MEDICAL TREATMENT FACILITY.

SYSTEM DOCUMENTATION INCLUDES:

a) FUNCTIONAL DESCRIPTION - DESCRIBES THE FUNCTIONAL REQUIREMENTS USED AS A BASIS FOR SYSTEM DEVELOPMENT. PROVIDES INFORMATION ON PERFORMANCE REQUIREMENTS, PRELIMINARY DESIGN, USER IMPACT, DATA RELATIONSHIPS AND DATA FLOWS BETWEEN QUALITY ASSURANCE PROCESSES AND PATIENT ADMINISTRATION FUNCTIONS.

b) SYSTEM SPECIFICATIONS - PROVIDES A DETAILED DEFINITION OF THE SYSTEM FUNCTIONS AS WELL AS INTERFACES WITH OTHER SYSTEMS AND SUB-SYSTEMS.

c) USERS MANUAL - PROVIDES NON-ADP PERSONNEL WITH THE INFORMATION NECESSARY TO EFFECTIVELY USE THE SYSTEM.

d) INSTALLATION GUIDE - CONTAINS STEP-BY-STEP INSTRUCTIONS FOR INSTALLING AQCESS ON THE DEC PDP-11/84 COMPUTER.

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1300 Piccard Drive
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FUNCTIONAL DESCRIPTION

for an

AUTOMATED QUALITY OF CARE EVALUATION SUPPORT SYSTEM

(AQCESS)

ISSUE 1.0

(REVISION 1.0)

4 DECEMBER 1985

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SECTION 1. GENERAL

1.1 Purpose. This Functional Description (FD) for the Automated Quality of Care Evaluation Support System will serve the following purposes:

a. It will describe the requirements to be satisfied which will serve as a basis for mutual understanding between the user and the developer.

b. It will provide information on performance requirements, preliminary design, and user impacts.

c. It will define relationships and data flows within the Quality Assurance processes and explain the relationships to Patient Administration functions.

1.2 Project References. The following references are applicable to the history and development of this project.

a. DoD Standard 7935, Automated Data Systems (ADS) Documentation, February 15, 1983.

b. MUMPS Patient Administration System Program Maintenance Manual (Draft); National Data Corporation Federal Systems, Inc. (NDC/FSI); April 6, 1984.

c. Functional Description for CHCS Patient Administration (PAD) (Version 2.0); NDC Federal Systems, Inc.; February 17, 1984.

d. MUMPS Patient Administration User Handbook (Draft); National Data Corporation Federal Systems, Inc. (NDC/FSI); April 6, 1984.

e. Functional Description for Tri-Service Patient Administration System (Army Version); TRIMIS Program Office (TPO); June 9, 1983.

f. Functional Description for Tri-Service Patient Administration System (Navy Version); Libra Technology; June 30, 1983.

g. Functional Description for Tri-Service Patient Administration System (Air Force Version); TPO; June 30, 1983.

h. NAVMEDCOM 6320.7; Quality Assurance Guide (Draft); September 1984.

i. NAVMEDCOM 6320.8; Credentialing Program (Draft); September 1984.

j. AR 40-66, (Change 2) Chapter 9; Medical Recorded Quality Assurance Administration; December 1, 1982.

k. AFR 168-13; Quality Assurance in the Air Force Medical Service; May 31, 1984.

l. AFR 168-4; Administration of Medical Activities; July 22, 1983.

m. AFR 168-695; Medical Administrative Management System (Vol I & Vol II) July 18, 1980.

n. AFR 205-16; Automatic Data Processing (ADP) Security Policy, Procedures, and Responsibilities; August 1, 1984.

o. DoDD 5200.28; Security Requirements for Automatic Data Processing (ADP) Systems; December 18, 1972.

p. DoDD 5200.28-M; ADP Security Manual; January 1973.

q. AR 380-380; Automated Systems Security; April 15, 1979.

r. AFR 300-13; (as amended) Safeguarding Personal Data in Automatic Data Processing Systems; March 14, 1976.

s. AFR 125-37; The Resources Protection Program (PA; May 6, 1982 (and change 1)).

1.3 Terms and Abbreviations.

A&D	Admission and Disposition
ACLS	Advanced Cardiac Life Support
ADP	Automatic Data Processing
ADT	Admission, Disposition, and Transfer
AIDS	Automated Inpatient Data System
AMEDD	Army Medical Department
AMH	Accreditation Manual for Hospitals
AQCESS	Automated Quality of Care Evaluation Support System
ASMRO	Armed Services Medical Regulating Office
ATLS	Advanced Trauma Life Support
CHCS	Composite Health Care System
CPP	Credentialing/Privileges Process
CPU	Central Processing Unit
CR	Clinical Records (Inpatient Records)
CRID	Clinical Record Identification (Inpatient Record Identification)
CRT	Cathode Ray Tube
CT	Coding Transcript
CTT	Coding Transcript Tape
DEERS	Defense Enrollment Eligibility Reporting System
DoD	Department of Defense
ES	Emergency Service
FD	Functional Description
FMP	Family Member Prefix

HA	Health Affairs
HIS	Hospital Information System
ICD	International Classification of Disease
ICP	International Classification of Procedure
ID	Identification
IG	Inspector General
IR	Inpatient Records (Clinical Records)
IRID	Inpatient Records Identification (Clinical Record Identification)
ITRCS	Inpatient Treatment Record Cover Sheet (Clinical Record Cover Sheet)
JAG	Judge Advocate General
JCAH	Joint Committee for Accreditation of Hospitals
MPAD	MUMPS Patient Administration System
MAMS	Medical Administrative Management System
MEB	Medical Evaluation Board
MTF	Medical Treatment Facility
MTRC	Medical Treatment Recording Card
MUMPS	Massachusetts Utility Multi Programming System
NDC/FSI	National Data Corporation/Federal Systems, Inc.
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
PAD	Patient Administration
PTID	Patient Identification
QA	Quality Assurance
QAC	Quality Assurance Coordinator
QAP	Quality Assurance Program
QAS	Quality Assurance System (Navy Use Only)
R/ADT	Registration/Admission, Disposition, and Transfer
RFP	Request for Proposal
RIPT	Record of Inpatient's Treatment
SSN	Social Security Number
TPO	TRIMIS Program Office
TRIMIS	Tri-Service Medical Information System
TRIPAD	Tri-Service Patient Administration System
UCA	Uniform Chart of Accounts
VSI/SI/SC	Very Seriously Ill/Seriously Ill/Special Category

SECTION 2. SYSTEM SUMMARY

2.1 Background. The increase in medical knowledge, the increasing sophistication of medical technology, the growing complexity of medical treatment facility (MTF) services, and the rapid emergence of new health professions have changed the complexion of health care delivery in the United States and in the Military Direct Care System. Diagnostic and treatment procedures have become more complex; and the level of education of the American public has improved dramatically, contributing to greater awareness of and increased expectations from the health care field.

During the past several years, incidents of improper or questionable health care have occurred in MTFs as well as in the civilian health care sector. These occurrences have raised questions in the Congress, in the Department of Defense (DoD), and within the military services about the quality of care being provided to eligible beneficiaries at MTFs. DoD desires to develop the ability to better assess and monitor the quality of care provided by the DoD health care system.

The TRIMIS Program was formally created on July 11, 1974, by the Department of Defense Assistant Secretaries of Defense (Comptroller, and Health and Environment). The program, created by DoD Directive 6000.5 is now managed and administered by the TRIMIS Program Office (TPO) of the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)). Its purpose is to consolidate previous Service efforts and to "improve the effectiveness and economy of health care delivery in the Army, Navy, and Air Force." As this original tasking assignment stated, "TRIMIS will include development of automated information systems for timely patient-centered health data, supporting medical services, clinical research, epidemiological, and health care information."

The TPO has developed a microcomputer-based Clinical Records and Patient Administration System using the MUMPS language and certain utilities form the Veterans Administration File Manager. The Clinical Records portion of the system collects an estimated 85 percent of the data elements and 99 percent of the volume of data required for a quality assurance provider profile. The system has had extensive TriService input and is designed for efficient use by current patient administration personnel, and incorporates extensive service specific edits of data to insure reliable and accurate data collection. The system is designed to be easy to learn, to provide on-line assistance to users, and to operate without dedicated computer operators and special environmental conditions. Being written in ANSI MUMPS, it can operate on a wide range of hardware and is capable of modification both to correct problems and to incorporate additional requirements. The system development was suspended following redirection of the TRIMIS program in March 1984. The AQCESS system will be developed from the existing PAD software. The software must be completed to include Military Department Clinical Records and QA requirements.

2.2 Objectives. The overall objectives of the Automated Quality of Care Evaluation Support System are to:

a. Improve the quality and timeliness of the evaluation of health care.

b. To provide administrative support for inpatient episodes.

c. To support the identification of variations which could adversely affect the quality of health care.

2.2.1 The Automated Quality of Care Evaluation Support System. The Automated Quality of Care Evaluation Support System is an integrated terminal-oriented, interactive, on-line computer system capable of gathering, storing, and rapidly retrieving information. The system contains registration data about military personnel, their eligible dependents, and other eligible beneficiaries admitted to the MTF. It also reflects admission, disposition, and transfer data necessary to administer the MTF's inpatient population. The system will provide QA related data bases, data entry capabilities, support to QA analyses, and reports. Additional requirements and substantial changes to the benchmark requires processor capability in excess of the minimum needed to carry out the QA functions. This additional compacting power will allow for expected enhancements as the QA requirements are refined. The software will be capable of orderly functional enhancement in support of inpatient QA, emergency service QA, and additional PAD requirements.

2.2.2 Information Requirements. The system will automate the information requirements of the inpatient and emergency service QA functions of DoD hospitals to make more efficient the effort required to collect, store, modify, retrieve, and report administrative and QA management data. The system will automate those PAD functions which support QA activities.

2.2.3 Information Capabilities. The AQCESS will be an integrated system allowing the information collected during patient admission, disposition, transfer, as well as clinical records activities, to be used by the Quality Assurance subsystem. The QA subsystem will also contain specific functions for collecting, maintaining, and reporting from the integrated system data base. This will allow most QA and PAD data to be collected as a byproduct of normal clinical record and patient management activities. This data can be sorted, collated, and reported as necessary to support MTF QA requirements.

2.2.4 Scope. The AQCESS project will provide automated information system capabilities to DoD MTFs with operating inpatient beds. The project will include the design, development, and acquisition of medical ADP capabilities to enhance the administrative procedures, and the ability of the Military

Medical Departments to monitor the quality of care being provided within their respective MTFs.

2.2.5 AQCESS Project Goals.

a. Improve the quality, effectiveness, economy, and risk management of health care delivery in DoD MTFs.

b. Centralize and coordinate the development and acquisition of ADP capabilities in support of QA in DoD MTFs.

c. Provide a standard automated quality assurance system with sufficient flexibility to accommodate future enhancements.

d. Install QA systems without major site preparation.

e. Minimize duplication of the data collection effort in the MTF.

2.2.6 Support. The AQCESS will include selected clinical and administrative functions supporting patient care, health care providers, MTF management and operation, and patient medical information. It will provide automation support to the information collection, processing, and reporting functions of DoD hospitals so that QA requirements can be met with minimal impact on personnel and manpower requirements.

2.3 Existing Methods and Procedures. The following are existing manual procedures currently used by each service. Since the QA program is a new requirement imposed upon the Military Departments, the existing manual systems do not reflect all necessary capabilities for performing these new requirements. The automated system described in this document contains functions and provides support to activities not presently being performed in military hospitals.

2.3.1 Army. In general, there are no computerized methods currently in use for QA activities within the Army Medical Department (AMEDD). Ongoing review of care provided (patient care assessment) is accomplished manually via random selection of records based on diagnosis in addition to a 100 percent review of all deaths and complications.

All provider credential files are maintained manually. This includes data entry, deletion of data, and compilation of statistics. Decredentialed provider reports are also prepared on a quarterly basis for submission to the QA office.

Review and evaluation of resource utilization and all risk management activities are accomplished in the manual mode. This includes blood and antibiotic utilization, review of all unusual occurrences, and patient or family complaints. Examples of occurrences being screened are:

a. Transfusion reactions

b. Abnormal diagnostic reports not addressed by health care

c. Unplanned return to the operating room

d. Unplanned transfer.

Manual occurrence screening is currently being accomplished in two AMEDD treatment facilities on a test basis. Final reports have not been received; however, verbal reports support the labor-intensiveness of the screening process.

2.3.2 Navy. The existing QA functions are supported by manual processes to collect, store, and report information. There is presently no automated means for performing these tasks.

Ongoing quality and appropriateness of care reviews, credentials process, and medical staff monitoring review are all accomplished in the manual mode. Examples of QA review functions are:

a. Medical Records Review

b. Surgical Case Review

c. Antibiotic Usage Review

d. Pharmacy and Therapeutic Review

e. Blood Utilization Review

f. Infection Control Review

g. Credentials Review

2.3.2.1 Other Data Sources. Information also comes from:

a. Incident Reporting

b. JCAH and IG Surveys

c. Patient Surveys

d. Consumer Councils

e. Liability Claim Review

f. Patient Contact Program

How these various pieces of the Quality Assurance System (QAS) interact within the system is discussed below. Input, output, and retained data are best described in terms of each of the seven QAS functions previously stated in paragraph 2.3.2.

2.3.2.2 Criteria-Based Review and Reporting Process.

Input

The crux of the Navy's medical staff monitoring reviews, and quality and appropriateness of care reviews, lies in the criteria-based review and reporting process.

Under the current system, pre-established problem identification criteria are not generally used in the review process, although such criteria are desirable in order to ensure consistent problem identification.

Output

Under the present system, the results of the review process enter the QA program in a multitude of formats. A great deal of time and effort must be spent by QA personnel culling from a large volume of paper the salient information about what problems each review has addressed and what solutions, if any, have been proposed.

2.3.2.3 Prioritized Monitoring System. The navy utilizes the "problem focused approach" to attain QA through problem identification, assessment, prioritization, resolution, and monitoring of corrective actions. Output from the current QA process is manually created reports.

Generic screening, trend analysis, and provider/facility profiles are accomplished on an as needed basis since there are no stated requirements at the present time.

By its very nature, the QA program involves the collection, retention, and correlation of significant amounts of information obtained from a variety of sources. Current personnel resources do not permit orderly collection or evaluation of information since hard-copy sheets or reports are often the only collection medium available. The infusion of additional personnel would not significantly improve the situation, since the evaluations performed often require multiple manipulation of data to evaluate different hypotheses. Without

automated support, the addition of personnel needed to manually process information to meet minimum objectives quickly becomes cost prohibitive.

2.3.2.4 Generic Screening. Generic screening is a method of conducting concurrent or retrospective review of medical care that is independent of diagnosis. It is sometimes called occurrence screening because it is a screening of all occurrences identified in all medical records which do not conform to prespecified criteria. In order to be effective, all patient medical records must be processed.

Until recently, there was no stated requirement for generic screening. However, it is an invaluable tool in identifying areas which may be potential QA problems.

In response to the recent requirement, a small amount of screening is now being done, but it is accomplished sporadically due primarily to the amount of personnel resources required to perform this type of task. When it is being done, the screening criteria vary from facility to facility.

Output

The output of the generic screening now being done is generally in the form of a memo or non-standardized report.

2.3.2.5 Trend Analysis.

Input

Trend analysis is a way of analyzing a large volume of data over a period of time in order to identify a pattern of activity. Since it can operate across departments and services, it is very helpful in tying together a number of seemingly unrelated occurrences into an identifiable problem.

This entire process can be performed in minutes or, at the most, hours with automation. Manually, it is, practically speaking, almost impossible.

In the current Navy QAP, almost no trend analysis is being done. When trend analysis is performed, it is done sporadically and on an as needed basis.

Output

The output of the trend analysis that is being done is a manually produced report.

2.3.2.6 Provider/Facility Profile.

Input

A provider/facility profile is a compilation of performance data which can be used to compare the performance of a medical entity (provider, department, or facility) on specified criteria to the performance of a comparable entity or group. The provider/facility profile is the most powerful QA tool in providing a line of accountability for a specific problem or trend to specific providers, departments, or services.

At the present time, provider/facility profiles are rarely done. When they are done, it is on a manual basis and is usually for a specific reason.

Output

The output of current provider/facility profiles are manually produced reports. They are neither used in the credentialing process or created to determine the extent of an already identified problem.

2.3.2.7 General Output from the Quality Assurance Program (QAP). The outputs from the QAP include reports to assist in efficient prioritization and tracking of problems, maintenance of provider profiles, new policies and procedures, staff education, staff counselling, clinical privileges, documentation for Navy and JCAH accreditation, and documentation for the commands. In addition, QA provides data on potentially litigious problems to the QA Committee.

Unfortunately, the usefulness of these reports is somewhat limited. While BUMEDINST 6320.62 specifically requires the different service/department/activity reviews to document the results of their reviews, it sets no standard for the format of this documentation. Under the current Quality Assurance System (QAS), each medical facility's reports are different in format and content, which makes comparison and correlation of information among them almost impossible.

2.3.3 Air Force.

2.3.3.1 Background. Existing approaches to quality assurance monitoring in the Air Force center around manual, labor- and paper-intensive reviews of medical records, hospital incident reports, committee actions and follow-ups, recurring retrospective reports from the standard Air Force Medical Administrative Management (MAMS), Automated Inpatient Data System (AIDS) (7109 reports) produced at Major Commands, credentialing documents, and AF QA/RM

cross-feed reports. Details of the existing program are specified in AFR 168-13, Quality Assurance in the Air Force Medical Service, 31 May 1984 and AF Regulations 168-4 and 168-695 which detail the biostatistical reporting system used for inpatient data, AIDS, and the appropriate elements of JCAH Standards specified in the Accreditation Manual for Hospitals (AMH).

2.3.3.2 Objectives of AF Quality Assurance Program. The full set of objectives for the existing program is contained in AFR 168-13. The general intent of the program is to improve the quality of health care delivery and enhance practitioner clinical performance. Objectives supporting that goal include reducing risk-creating incidents and adverse effects on patients, enhancing coordination and communication among providers and services, improving provider screening, selection, and accession processes, and assuring prompt identification of impaired providers.

2.3.3.3 Current Activities. The activities currently under way to meet the stated objectives are generally supported by Major Commands (MAJCOM) and Headquarters-level automation. Base level input is keypunch entry of data with cards sent to MAJCOMs for actual data entry and editing. The activities involved fall into the following categories.

a. Medical record and professional personnel perform retrospective review of medical record data/patient care after the fact; little prospective or concurrent review is now accomplished.

b. AF Form 765, Hospital Incident Statement, is submitted by an initiater to the Risk Manager who monitors action/follow-up through the MTF committee structure.

c. Committees perform retrospective peer review.

d. Retrospective AIDS 7109 Reports are used for dat and reporting needs. They provide infection, complication, death, and other provider performance data. They also include diagnosis and procedure indexes, and related length of stay analysis.

2.3.3.4 Deficiencies of the Current System. The current system is a composite of existing automated and manual systems with some added review and reporting requirements. It is in a stage of evolution and will require changes as experience builds, sophistication increases, and medical standards change. The major problems with the current system are:

a. It does not provide an integrated mechanism for quality of care evaluation.

b. It does not provide system-generated edits for data entered at base level.

c. It is very labor-intensive to collect, manipulate, and report data.

d. No provision is made at the MTF level for the convenient retrieval and manipulation of data to meet ad hoc management information needs whether it be for patient care, credentialing/privileges process (CPP), resource allocation, or answering the ever-increasing inquiries from higher levels in the chain of command.

2.4 Proposed Methods and Procedures. The following sections describe the expected improvements and impacts of the AQCESS.

2.4.1 Summary of Improvements. MTF command, professional, and administration staff will have automated support to assist in the management of the QAP within the facility. Individual patient data, occurrence screening, incident tracking, and provider profiling information can be entered into the automated system. Provider profiles and other QA reports can be generated at the MTF using the data stored in the system.

Much of the patient data required for QA and provider profiling is obtained from the Patient Administration processes leading to and including the Clinical Record Cover Sheet and Coding Transcript. To prevent duplication of effort at the MTF, automated support will be provided to the Admissions and Dispositions sections and the Clinical Records sections of the facility so that their portion of the QA data will be collected as a byproduct of the normal work performed by these sections.

2.4.2 Summary of Impacts. The following sections describe the impact of the AQCESS.

2.4.2.1 User Organization Impacts. The AQCESS will support the identification, tracking, and documentation of QA activities within the MTF. The manual mode of data collection and analysis in the QAP will be supported by automated functions. The MTF Commander, the Administrator, the QA Coordinator, the QA and Credentials Committees, and other appropriate individuals (as specified by the Hospital Commander) will have the capability to review pertinent information relating to the QAP as appropriate in a rapidly retrievable, user-controlled format. The MTF will be supported by current information in quality of care decisionmaking.

The QA Coordinator, or other individual as designated by the MTF Commander, will have the responsibility of maintaining the QA data base, control of the system functions, and the security of the system.

The system will not replace manual screening of records to identify occurrences. Professional expertise and judgment will have to be applied through existing committee/review structures to identify variations in the quality of care to be entered into the AQCESS.

Patient Administration, QA, and other personnel will require training on the system. Training of new personnel and maintaining skills of previously trained personnel will be a new mission of the MTF.

2.4.2.2 User Operational Impacts. The AQCESS will provide the MTFs with data bases containing occurrence screening, provider mortality rate, blood utilization, incident reporting, provider profile, and QA activity/problem information. Analysis which heretofore could not be easily performed in a manual system because of lack of personnel can be performed using information available from the automated system.

The QA functions are essentially new functions for most of the facilities. Thus, implementation of the AQCESS will generate additional tasking for MTF personnel.

Clinical records personnel will be positively impacted in that the Clinical Record Cover Sheet and the Coding Transcript will be essentially complete except for coding when clinical records receives them. The diagnosis and procedure classification codes will have to be entered, information edited to verify the data is correct, and the record reviewed for completeness.

The report function of the system will allow the printing of biostatical and QA reports at MTF-specified times.

The security function will be the key to system utilization. All user access to the system and to data it contains will be controlled by the security function. The security tables will authorize each individual's access and use of functions.

The functions that will be provided to the MTF by the AQCESS are:

Registration Processing
Admission Processing
Disposition Prpocessing
Transfer Processing
R/ADT Reports
Inpatient History
Patient Inquiry
Clinical Records Processing
Clinical Records Reports
Bed Management Processing
Correction Management
System Management
Quality Assurance
Provider Profiling

2.4.2.3 User Development Impacts. The Military Department TRIMIS elements and the MTFs will be involved in preparation for the system. The MTF will be expected to develop local tables and files with contractor assistance. User and System Manager training, installation, and data conversion at each site will be provided by the software support contractor. Site preparation and facility modification will be the responsibility of the Military Department and the site. The TPO will provide site preparation and implementation guidance and funding.

2.5 Assumptions and Constraints.

2.5.1 Specific Assumptions.

Specific assumptions regarding the AQCESS are:

a. The AQCESS is being developed to support the QA requirements as specified by OASD(HA) in conjunction with individual Military Departments.

b. The AQCESS is being developed to support the QA requirements found in AR 40-66; NAVMED Instructions 6320.7 and 6320.8; AFR 168-13; and further stipulations from OASD(HA).

c. The AQCESS will use available standard data elements, items, and codes for the three Services.

d. Personnel from HA, TPO, and functional representatives from the Military Departments will be actively involved during system design, development, testing, deployment, and operation.

e. Existing Government-furnished MUMPS PAD software will form the nucleus of the QA software.

f. Thorough testing of each functional application of the system will be accomplished via prototype testing prior to proliferation.

g. A refinement of objectives, functions, and system organization will be gained from the development, installation, evaluation, and operation of the system.

h. The TPO will identify a method which will preclude duplicate data entry at sites which currently operate PAD systems.

2.5.2 Constraints.

It is required that:

a. Medical, personal, and privileged Quality Assurance information contained in the AQCESS must be safeguarded in accordance with appropriate public laws and regulations.

b. Conversion of the manual system will be done in the most cost-effective manner possible.

c. The system must be flexible and easy to use by hospital personnel not experienced in ADP.

d. Operation of the system must not require computer operators.

e. The system must operate in a normal office environment without major site preparation.

SECTION 3. DETAILED CHARACTERISTICS

3.1 Specific Performance Requirements. This subsection describes the performance requirements for the proposed AQCESS.

3.1.1 Accuracy, Precision, and Validity. The AQCESS will ensure data accuracy and validity by editing all input, update, and inquiry data from system users. Data transmitted between functions and/or logical segments of the system will be subjected to error checks including:

a. Redundancy checking of recorded data. This is to ensure that data sets are not duplicated inappropriately.

b. Integrity checking of data sets before commencing system operations; i.e., all links are still in place, data has not been corrupted in any way, disk has not crashed, etc. This should always occur before the system is booted.

c. Consistency editing of data contained within the system.

d. Editing of input data with expected values or ranges.

3.1.2 Timing. The system timing requirement is to support the on-line terminal environment in a manner conducive to user acceptance by providing current, accurate, and easily input and retrieved patient data. Terminal response time will vary with the task being performed since search and list functions take more time than the retrieval of a single known data element. System response time requirements are described below.

3.1.2.1 Interactive Response Time. Interactive processing occurs when the user communicates with the system in a conversational manner; that is, the content of the user's input is in response to and limited by the preceding system output. Interactive response time is measured from the moment the "return," "transmit," "enter," or equivalent so-called "user signal" key is pressed until the moment the last response character appears on the screen. Maximum terminal interactive response times will be no longer than 2 seconds for 95 percent of interactive functions. The average response time for the remaining 5 percent will be no longer than 5 seconds. Extensive data base searches and extensive file updates are excluded from the response time requirements and are described in section 4.2.2.3, Data Base Response Time. Interactive terminal response time requirements do not apply to external system interface activity, the generation of output products, reports, or other batch operations.

However, screen-to-screen terminal response time must be 2 seconds or less for 95 percent of the executions of terminal functions and average no more than 5 seconds for remaining 5 percent. Response time is measured from the moment the "transmit" key is pressed until the moment the first response character is displayed on the terminal. The screen must be completely filled within 10 seconds of pressing the "transmit" key. Functions that support a user "signing on" the system and those functions that require extensive data base search operations, such as name fragment or other candidate searches, are excluded from the response time requirements. Interactive terminal response time does not apply to the DEERS interface, the generation of output products, reports, or any other batch operations.

3.1.2.2 On-Demand Response Time. Hard-copy output is produced on demand when its production is requested either explicitly (e.g., the user requests an embossed card to be printed) or implicitly (e.g., the completion of registration will cause a registration form to be printed). On-demand response time requirements are measured in terms of internal system output production.

a. A hard-copy request issued from an interactive terminal will be processed in a manner that avoids:

   1. Tying up the requesting terminal while hard-copy is being generated, except where output is being produced on an integrated slave printer attached to the requesting terminal.

   2. System lock-out of requesting terminal due to a hardware/software failure in the output generation subsystem.

b. The response time requirement for on demand output will be measured from the time the request is transmitted until the moment the output is either initiated or initial output is queued (with a message to the user) for the device. The response time for this activity should not exceed 3 seconds.

c. These timing requirements do not apply to delays caused by inoperable printers. Response time requirements for extensive data base search functions and external system interface activity are as follows:

   1. The system will be available to the user for the next task or action within 5 seconds.

   2. The output product will begin printing or be placed in an output queue within 10 seconds.

   3. Print time per product will not exceed 1 minute per page.

   4. Print time per page or screen for screen-copies and on-line slave-mode echo-prints will not exceed the greater of the times specified above, or 20 seconds per page or screen based on

screen-sized displays, as discussed in section 4.2.2.4.b, Screen-Fill.

3.1.2.3 Batch Turnaround. Batch reporting turnaround time will not exceed 1 hour (4 hours for ad hoc reports including extensive manipulation of data and extensive data base searches) measured from the time an approved request is initiated by the user to the time the requested report has begun to print.

3.1.2.4 Throughput. It is anticipated that most of the QA workload, excluding batch reports and ad hoc requirements, will be processed during the normal 8 hour workday. Except for scheduled maintenance, the system will be operational and on-line for 24 hours a day, 7 days a week.

Scheduled outputs will be produced by the system on the specified frequency basis (i.e., daily, weekly, monthly, quarterly, or annually). Although these outputs normally occur in batch and often during non-duty (e.g., evening) hours, the day of the week (for weekly or less-frequent outputs) and the time of day and frequency of their initiation will be specified by each MTF. Similarly, the MTF may elect a different day (or time) for each output, or request output products on demand.

3.2 Functional Area System Functions.

3.2.1 Functions. The automated system described in this document contains functions and provides support to activities not presently being performed in military hospitals. As user personnel gain experience with the system and as new requirements are developed, the system will be modified to accommodate those requested changes.

a. The initial (Phase I) functions of the QA subsystem of AQCESS are:

- o Occurrence Screening, Inpatient and Emergency Services
- o Incident Reporting
- o Problem Audit Tracking
- o QA Function Reports
- o Provider Profiling
- o Profiling Reports.

Plus, adjunctive functions of:

- o Registration
- o Admission
- o Disposition
- o Transfer
- o R/ADT Reports
- o Inpatient History
- o Patient Inquiry
- o Clinical Records
- o Clinical Records Reports
- o Bed Management
- o Correction Management
- o System Management.

b. Phase I will also include a Training component.

c. Functions to be added in Phase II are:

- o Embosser Interfaces (Phase II)
- o Ad Hoc Reports (Phase II)
- o DEERS Interface (Phase II).

Phase II requirements must be defined during initial systems design. Ad hoc query is desired in the Phase I deployment but if not available, must be implemented not later than 180 days after Phase I capabilities. The installation of Phase II functions will be handled in the same manner as routine software updates specified in the software contract. Other as yet not fully defined capabilities are expected to be identified. These will be processed as system change requests per Annex M of the TRIMIS Master Plan.

3.2.2 Quality Assurance. Following approved MTF policies and procedures, the QA function will support the monitoring of quality of care and the identification and documentation of potential or recurring problems and corrective actions.

QA data will be available only to authorized users of the QA function. To maintain the confidentiality of the data collected by the AQCESS, appropriate reports and displays will be transmitted through the system only by authorization of designated users at designated terminals.

The Quality Assurance subsystem of AQCESS will consist of the Quality Assurance and Provider Profiling functions. These functional components are discussed in the following paragraphs.

3.2.2.1 Quality Assurance Function. The QA Function will provide an interactive data base capability for assisting in occurrence screening and occurrence screening audits, and for monitoring quality of care indicators and problems occurring in an MTF.

General objectives of the QA function will be:

a. To assist in the Occurrence Screening Program for both inpatients and Emergency Services patients.

b. To collect and report data on incidents and areas of high risk within an MTF.

c. To identify, document, and track quality of care problems, including solutions, recommendations, re-evaluation dates, and follow-up activities.

d. To identify trends relating to patient care according to specified criteria using ad hoc reporting.

e. To produce reports and displays of requested information on occurrence screening, incident reporting, and problem audit functions.

3.2.2.2 Provider Profiling Function. The system will provide an interactive data base capability for the identification, documentation and tracking individual Health Care Provider's (HCP) clinical and professional activities to support the credentials program within the MTF. The system will provide the capability to document the HCP's patient care profiles which include data produced through the occurrence screening subfunction, procedure/ mortality tracking, and administrative data, including the provider's speciality, dates of licensure, training, etc. The Profiling function will also generate management reports such as the Credentials Pull List.

3.2.3 Training Component. The system will include a training component that will allow the user to enter a training partition that supports all functions of the live system, without impacting the live data base in any way. The functions contained in the training partition will be updated to reflect changes made to the operational system.

3.3 Inputs/Outputs. This paragraph lists the data, forms, and reports that constitute the input to QA subsystem of AQCESS, and the reports that are output from this subsystem. These inputs and outputs are defined in paragraph 3.4 and Appendix A of this document. (PAD inputs and outputs are fully defined in project references listed in paragraphs 1.2b through 1.2g.)

a. QA Subsystem Inputs

- Provider Occurrence Screening Checklist
- Provider Emergency Service Occurrence Screening Checklist
- Provider Occurrence Screening Audit data
- Provider Emergency Service Audit data
- Incident Report
- QA Problem Audit data
- Provider Mortality Peer Review Comments
- Provider Profile

b. QA Subsystem Outputs

- Blood Utilization Pull List
- Credential Pull List
- Delinquent Occurrence Screening List
- Incident Summary
- Diagnosis Index by Provider
- Dispositions by Diagnosis Report
- Occurrence Screening Pull Lists - Emergency Service and Inpatient
- Occurrence Screening Summary - Facility, Emergency Service and Inpatient (raw and validated data versions)
- Occurrence Screening Summary - Provider, Emergency Service and Inpatient (raw and validated data versions)
- Occurrence Screening Summary - Specialty (Inpatient) (raw and validated data versions)
- Occurrence Screening Suspense List - Emergency Service and Inpatient

- o Provider Occurrence Screening Audit - Emergency Service and Inpatient
- o Provider Procedure/Mortality Summary
- o Provider Procedure Summary
- o Provider Profile
- o Providers with Insufficient Continuing Education
- o Quality Assurance Problem Audit
- o Surgical Index by Provider
- o Surgical Operations Report

3.4 Data Base Characteristics. Following is a summary of the AQCESS data base arranged by major QA subfunctions, listing inputs and outputs for each subfunction. Appendix A breaks each input and output down to the data element level.

3.4.1 Quality Assurance Subfunctions.

3.4.1.1 Occurrence Screening Subfunction (Inpatient and Emergency Service).

Inputs: Provider Emergency Service Occurrence Screening Checklist (PESOSC)

Provider Occurrence Screening Checklist (POSC)

Outputs: Delinquent Occurrence Screening List (DOSL)

Occurrence Screening Pull List - Emergency Service

Occurrence Screening Pull List - Inpatient (OSPL)

Occurrence Screening Summary - Facility, Emergency Services (FESOSS)

Occurrence Screening Summary - Facility, Inpatient (FOSS)

Occurrence Screening Summary - Provider, Emergency Service (PESOSS)

Occurrence Screening Summary - Provider, Inpatient (POSS)

Occurrence Screening Summary - Specialty (Inpatient) (SOSS)

Occurrence Screening Suspense List - Emergency Services (ESOSSL)

Occurrence Screening Suspense List - Inpatient (OSSL)

Provider Occurrence Screening Audit - Emergency Service (PESOSA)

Provider Occurrence Screening Audit - Inpatient (POSA)

3.4.1.2 Incident Reporting Subfunction.

Input: Incident Report (IR)

Output: Incident Summary (IS)

3.4.1.3 Problem Audit Tracking Subfunction.

Input: (User entered audit parameters)

Output: Quality Assurance Problem Audit (QAPA)

3.4.1.4 Blood Utilization Review Subfunction.

Input: (Extracted from existing AQCESS data bases)

Output: Blood Utilization Pull List (BUPL)

3.4.1.5 Other QA Function Outputs.

Diagnosis Index by Provider

Dispositions by Diagnosis Report

Surgical Index by Provider

Surgical Operations by Report

3.4.2 Provider Profiling Functions.

Input: Procedure Mortality Peer Review Comments (PMPRC)

Provider Profile (PP)

Output: Credential Pull List (CPL)

Provider Profile (PP)

Provider Procedure Summary (PPS)

Provider Procedure/Mortality Summary (PP/MS)

Providers with Insufficient Continuing Education

3.5 Failure Contingencies. The system requirements for failure contingencies are delineated in the following paragraphs.

3.5.1 Hardware Failure. The system requirements for hardware failure contingencies are:

a. The system will gracefully power down in cases of electrical power failure.

b. If more than one host computer is involved, the loss of one host computer will not adversely affect the activities of the other host computer(s).

c. There will be a locally (MTF) developed contingency plan to cope with catastrophic hardware failure.

d. There will be a locally (MTF) developed contingency plan to cope with temporary hardware downtime.

3.5.2 Software Failure. The system requirements for software failure contingencies are:

a. The system software will be designed such that failure of one software process does not affect other software processes. For example, if the QA portion of the software fails, R/ADT will not also fail.

b. The system will provide for all data to be available after user-initiated system recovery is performed due to software failure, i.e., no patient data remains locked.

3.5.3 Continuing Manual Operations and Mass Data Entry. Manual methods and procedures of continuing registration, ADT, and business operations during a period of automated system unavailability will be established. Backup procedures must include those functions critical to maintaining hospital operational capability. The system will provide for the easy bulk entry of mass data obtained during manual backup operations. For example, in such a system, it would be desirable to be able to simply transcribe registration data directly into the terminal in a high volume and with as few screens as possible, rather than going through the usual multiple screen dialogues.

3.5.4 Restoring Lost Data. The system will be configured such that data backup media can be loaded to reduce major data loss. The system will provide a recovery capability for restoring data in the event of damage or loss.

3.6 Security. The system will provide the MTF-designated System Manager and the Security Manager (if any) with the capabilities to maintain system security and integrity; to track system and application software updates; to display, print, and edit system tables; to produce ad hoc reports; and to collect and report system use statistics.

3.6.1 Maintain System Security. The system will guard against unauthorized access to the system, its functions, and specific data base files by providing capabilities to generate and maintain user IDs and passwords, to perform automatic log-off, to limit user access, to create and maintain security profiles, and to maintain security logs. These capabilities are discussed in the subsections below.

3.6.1.1 Create and Maintain User ID Codes and Passwords. Each system user will have a unique user identifier (user ID code) and an associated password which will not be displayed (screen echo will be off) when entered into the system. The system will ensure that no use can be made of the system unless a correct user ID/password combination is first entered by the user and verified in the system tables. While the user ID will be unique and unchanging, the password will be changeable either by the System Manager or Security Manager as authorized by the MTF.

The following capabilities will be available:

a. The system will provide the capability to automatically generate random passwords, as well as to allow the System Manager to set or change access passwords. The MTF system Security Manager or the System Manager will determine which method to use in the MTF. All passwords must be labeled and protected as "For Official Use Only" information.

b. Before a user does any work via the system or accesses any data, the user ID and password will be entered and the system will verify them. Each invalid logon attempt will be written to the system security log (along with the time, date, terminal ID, and user ID), and the user will be allowed to try again. The MTF will specify the number of allowed invalid logon attempts. After the user has exceeded this number, the fact will be logged, printed on the operator's console, the terminal and user ID will be temporarily disabled until the System or Security Manager specifically re-enables both the terminal and the user ID.

c. The system will provide the capability to produce hard copy listings of all registered users. This listing will contain, at a minimum, the user's name and ID, clinic/work location, and security level.

3.6.1.2 Provide Automatic Log-Off. The system will allow the System Manager to set a time period beyond which the system will automatically log-off a terminal and return to the Sign-On Screen if it remains unused.

3.6.1.3 Limit User/File Access. The system will provide a security system that limits user and terminal access to only those functions, files, and data base segments that they are specifically authorized access. The system will maintain a table of each user and each terminal and the processing functions to which authorized access is allowed.

3.6.1.4 Create/Maintain Security Profiles. The system will provide the capability to create and maintain a security profile that will allow the System Manager to group privileges and assign them according to the one profile rather than having to assign a privilege for each task. The Security Manager will be able to tailor the basic default profile to meet the specific needs of various classes of users. For example, if a CR clerk has 10 options that have to be assigned, these 10 could be grouped into a CR Clerk Security profile, and the values assigned would become the default values for a CR clerk.

Profiles could also be made for QAC, etc. This basic profile, however, could be edited to meet the specific needs and training capabilities of selected individuals.

3.6.1.5 Maintain Security Logs. The system will automatically maintain logs of remote accesses, invalid log-on attempts, security violations, etc., as required by AR 380-380, AFR 205-16, AFR 300-13, AFR 125-37, DoDD 5200.28, and DoDD 5200.28M.

3.6.2 Ensure Privacy of Patient and Provider Data. The system will comply in full with the Privacy Act of 1974 and will provide complete facilities to enable full compliance of the MTF with the Act. Privacy Act messages/ statements will be displayed on all printouts, reports, and terminal displays that contain patient data or personal data. The statement will read as specified by each individual service, or as follows in the absence of a specification: "FOR OFFICIAL USE ONLY--PERSONAL DATA--PRIVACY ACT OF 1974 (PL 93-579, 5USC552a)". Privileged QA records will carry an additional label stating, "This is a medical QA document which cannot be released without approval of the MTF Commander."

3.6.3 Track System Data Updates. The following capabilities will be available for tracking updates to system data:

a. The system will automatically maintain with each stored record file or data segment, the date and time of last update, and the user ID of the user who updated the data.

b. The user will be able to enter an indication that an individual's record has been corrected and/or is in dispute. This will serve as a flag reference to a paper record or dispute and/or correction, per the Privacy Act.

3.6.4 Maintain System Tables. The system will allow the System Administrator to:

a. Maintain and update those tables that may be modified by the MTF including those tables which designate authorized users, user identification numbers, and authorized functions.

b. Maintain lists of tables which can be displayed on a screen or listed in a printout.

3.6.5 Produce Ad Hoc Reports. The system will provide the capability to produce ad hoc reports in response to user inquiries. This function will be oriented toward non-technical users and will allow them to request ad hoc reports. It will provide the following capabilities:

a. The system will allow the user to select, retrieve, sequence (sort), and format selected data.

b. The system will allow the use of boolean logic on multiple data selection fields (i.e., "and," "or," "not," etc.).

c. The system will provide the capability to store the entered statements and/or procedures to generate reports at a later time.

d. The reports will be requestable/specifiable on-line, but will be printed in batch. It is desirable that the reports additionally be requestable in off-line/batch mode also.

e. The system will additionally provide the same type of ad hoc reporting capability as specified above on a fully interactive, on-line, "real-time," terminal-display basis. However, any large, complex, or extensive data base searches (defined in Section 4.2.2.3 of this document) that may potentially degrade the system, its response time, or its use, can be processed on-line, but the requesting user's and the System Manager's consoles will be notified. Approval of on-line ad hoc reporting will then be obtained from the System Manager before proceeding.

SECTION 4. DESIGN DETAILS

AQCESS is a computerized system for managing QA and patient information at MTFs. It will be implemented under the sponsorship of the TRIMIS Program Office in their efforts to streamline information management. AQCESS is an automated system capable of performing a number of tasks.

4.1 System Description. The following summarizes the AQCESS subsystems and processes.

Access Control Functions

- User Entry
- PTID

Quality Assurance Subsystem

- Quality Assurance
- Provider Profiling

A&D (R/ADT) Subsystem

- Registration
- Admission
- Transfer
- Disposition
- Correction Management
- Bed Management
- System Management
- Inpatient History
- Patient Inquiry
- R/ADT Reports

Clinical Records Subsystem

- Clinical Records
- Clinical Records Reports

The capabilities of these subsystems are described in more detail in subsections 4.1.1 through 4.1.18. In addition, special functions that make it easier to use the AQCESS are described in subsection 4.1.19. The A&D (R/ADT) and Clinical Records subsystems are fully described in project references listed in paragraphs 1.2.b through 1.2.g.

4.1.1 Access Control Functions.

4.1.1.1 User Entry. User entry protects the system and its data from unauthorized users and restricts users to those processes they are authorized to perform. Specifically, this process:

a. Receives and verifies the user ID and password.

b. Controls which processes can be performed at each terminal.

c. Allows a user to access to authorized processes only.

4.1.1.2 Patient Identification (PTID). The system uses six unique items of information to identify each patient: register number, patient name, family member prefix (FMP), date of birth, sponsor's SSN, and sex. This identifying information or part of this information is entered in PTID before registering or admitting a new patient. Existing patient records must be located via the PTID process before those records cana be processed in any of the patient-oriented functions (i.e., Registration, Admission, Disposition, Transfer, and Inpatient History).

4.1.2 Quality Assurance Subsystem.

4.1.2.1 Quality Assurance Function. The Quality Assurance function can be broken down into four major functional areas:

- o Occurrence screening, including both inpatient and emergency service care.
- o Problem identification and tracking, by activity and status.
- o Identification of significant incidents and recall these incidents sorted to highlight various areas of high risk.
- o Reporting, including reporting occurrence screening, problem audit, incident summary, and blood utilization data.

a. Occurrence Screening. The system will assist in the Occurrence Screening Program for inpatients and for patients seen by the Emergency Service. The Provider Occurrence Screening Checklist (POSC) will be completed manually by the provider at the time of the patient's discharge from inpatient status. The Provider Emergency Service Occurrence Screening Checklist (PESOSC) will be completed manually by the provider at the time the patient is seen in the Emergency Room. The completed checklists will then be reviewed and input into the system.

The system will provide data extracted from records approved through the Clinical Records function so that the occurrence screening checklists can be completely entered into the system. The system will also assist the review process by generating a pull list of records that meet specified the occurrence screening criteria.

The Quality Assurance Coordinator will ensure the status and dates of reviews of a provider's occurrence screening variations and that the action taken as a result of the reviews is entered into the system.

When the review process is complete, the number of unjustified variations and the responsible provider name/identification will be posted to the Provider's Profile.

b. Problem Audit Tracking. The system will assist the Quality Assurance Coordinator in monitoring the statuses of solutions to problems which have arisen in the facility and have been designated by the QA Committee as requiring entry on the Quality Assurance Problem Audit.

c. Incident Reporting. Any reportable incident occurring in the MTF environs will be recorded on an Incident Report, which will be forwarded to the designated individual for input into the system. The system will provide a Incident Summary listing all or specified incidents, sortable by section. All sections will appear on each Incident Summary, but the chosen sort section will print in the left-most column of the report. This function supports tracking of incidents and action status. The system will allow users to enter action status codes indicating the action to be taken, and will report records requiring actions that have not been completed.

d. Reporting. The QA subsystem will produce the occurrence screening, incident, problem, and blood utilization reports listed in sections 3.4.1.1 through 3.4.1.5, and described in Appendix A.

The QA subsystem will assist in the Blood Utilization Review Program of the MTF by providing the Blood Utilization Report, a pull list of records which should be available for the Blood Utilization Review Committee to review. The system will extract the data for this report from the Clinical Records function. All input to this function will be system generated.

The Blood Utilization Review Committee may use this report to record review comments. Variations found after review of the patient's record will be submitted to the QA office for monitoring and follow-up action by the appropriate Clinical Service. When the review action is complete, the number of unjustified variations and the name/identification of the responsible provider will be provided to the Credentials Secretariat for inclusion in the provider's profile.

4.1.2.2 Provider Profiling Function. The Provider Profiling function will be accessible only to personnel designated by the MTF Commander, normally the Credentials Committee Chairman and the Credentials Committee Secretariat.

The MTF authorized user will record the required administrative data and clinical indicators necessary for inclusion on the Provider Profile and the Provider Procedure/Mortality Summary.

The user can query the system for a Credentials Pull List which is a list of providers by specialty, and their specified dates of next credentials review.

The Credentials Committee will use the Provider Profile and the Provider Procedure/Mortality Summary to assist in formulating their recommendations to the Commander regarding the privileges to be granted to the provider.

4.1.3 A&D (R/ADT) Subsystem.

4.1.3.1 Registration Function. To register a person into the system, the user records demographic information about the person and the person's sponsor via the registration process. The user can also use this process to display information on previous inpatient episodes and to print Registration Forms, which contain registration information on the patient. Specifically, Registration:

a. Collects, edits, and validates registration data, including:

   1. Patient's race, marital status, address, religion, and military ID card expiration date.

   2. Rank, branch of service, flying status of patient.

   3. Military occupation and unit ID, if active duty.

b. Automatically retrieves patient address data if any other family member's record is on file.

c. Allows the user to update and modify registration information.

d. Indicates whether the registration data has been reviewed and verified as correct by the patient or the patient's agent.

e. Allows a request to print registration forms.

f. Displays data on the patient's most recent previous inpatient episode.

4.1.3.2 Admission Function. When admitting inpatients to the MTF, the Admission process is used to collect information about the inpatient episode. The admission process is also used to create records for potential inpatients

preadmissions) and to track patients who are the administrative responsibility of the MTF. Specifically, Admission:

a. Ensures that inpatients are registered before admission proceeds.

b. Collects, edits, and validates admission information, which includes:

   1. Date, time, and source of admission; admitting physician; and diagnosis.

   2. Length of service (if active duty).

   3. Ward, physician, and clinical service assignments.

c. Captures, edits, and validates information on active-duty military who have Medical Evaluation Board (MEB) status, casualty status, or absent status.

d. Automatically generates a register number that identifies the patient's record if the MTF has chosen to have register numbers assigned by the system. (The MTF can choose to have register numbers assigned automatically or by the user; see paragraph 4.1.15 on the System Management process.)

e. Allows prospective inpatients to be preadmitted.

f. Allows the request for printing of Index Cards, embossed cards, and other admission documents.

g. Allows admission of newborns by automatically retrieving applicable data from the mother's record. Forces the user to change the newborn status if mother is dispositioned before the newborn.

h. Allows users to cancel an admission or convert an admission to a preadmission.

4.1.3.3 Transfer Function. The Transfer process enables the user to uopdate administrative data when an inpatient's ward, clinical service, or physician assignment is changed. This process also allows users to update data on the patient's emergency contact, MEB status, casualty status, and absent status, and to view other admission data, and to request printing of inpatient products.

4.1.3.4 Disposition Function. When dispositioning patients, the Disposition process is used to collect administrative data about the patient's release

from the MTF and to begin the final processing of the records on the inpatient episode. Specifically, Disposition:

a. Collects, edits, and validates disposition data, such as date and type of disposition, and physician ordering the disposition.

b. Removes the patient from active ward and clinical service records, which are used in system reports.

c. Allows a disposition to be cancelled.

d. Allows either dispositioning of newborns at the time of the mother's disposition, or tracking them as pay patients.

e. Allows the viewing of admission data and requesting of inpatient products.

4.1.3.5 Correction Management Function. Correction Management will be used to correct specific information that cannot be corrected through other AQCESS processes. Specifically, Correction Management allows:

a. Correction of the following fields as they appear in the patient record: patient category, length of service, source of admission, date and time of admission, date and time of disposition, disposition type, absent statuses, clinical services, and inter-ward transfers.

b. Addition of appropriate absent status, clinical service, and inter-ward transfer data omitted from a patient's record during admission.

c. Addition of remarks to the Admission and Disposition (A&D) Report: 1) to alert others that erroneous data was included on previous Admission and Disposition Reports and 2) to explain changes or additions described in (a) and (b).

4.1.3.6 Bed Management Function. The Bed Management function maintains statistics on the numbers of beds that are occupied or available on each ward and helps monitor ward statuses in the MTF.

Specifically, this process:

a. Adjusts and computes bed availability figures for each ward.

b. Allows the creation of new Ward Status records and deletion of existing Ward Status records. (A record cannot be deleted for a ward if there are any occupied or reserved beds on that ward.)

c. Displays total figures on bed availability for the entire MTF.

d. Allows the adjustment of the number of total beds and blocked beds on a ward.

4.1.3.7 System Management Function. The System Manager uses this function to maintain data that regulates AQCESS operation. Specifically, the process allows the System Manager to:

a. Designate authorized users and the functions and terminals for which they are authorized.

b. Maintain and update system tables.

c. Maintain lists of tables, which can be displayed on a screen or listed in a printout.

d. Maintain MTF profile data identifying the MTF, including branch of service. Also, to maintain profile data regulating certain system functions, such as whether register numbers are being assigned automatically or manually, dates for archiving files, and reserving or releasing blocks of register numbers for manual or automatic assignment to records.

4.1.3.8 Inpatient History Function. This process allows the review of information about patient episodes of active and dispositioned patients. Inpatient History keeps track of all inpatient episodes for an individual patient. It can display a list of episodes for a patient who has been admitted more than once, and the user can choose any one of the episodes for review. Specifically, Inpatient History displays:

a. Register numbers, admission dates, disposition dates, and admission diagnosis codes on patients with more than one inpatient episode.

b. PTID data, patient category, rank, branch or service, religion, source of admission, admission date/time, disposition type, disposition date/time, clinical service, ward, type case, and archive data on individual inpatient episodes.

4.1.3.9 Patient Inquiry Function. This process identifies segments of the patient population according to categories specified by the MTF, and lists patients who fall into those categories. The MTF may specify categories such as ward, physician, diagnosis, etc. For example, through Patient Inquiry the user may view a list of all inpatients currently on a given ward.

4.1.3.10 R/ADT Reports Function. Through this function, users enter requests to print the reports listed below. These reports, which are generated from data entered via the A&D subsystem processes, are described in detail in project references listed in paragraphs 1.2b through 1.2g and the AQCESS Users Manual.

a. Admission and Disposition Report.

b. Admission and Disposition Recapitulation or Patient Strength Report.

c. Admission Notification Letters.

d. Admission Summary by Name or Register Number.

e. Alpha Roster of Hospital Inpatients.

f. Command Interest Report.

g. Daily Admissions by Diagnosis.

h. Death Report

i. Disposition Notification Letters.

j. Disposition Summary by Name or Register Number.

k. Injury Report.

l. Long-Term Patient Roster.

m. Patient Charge Roster.

n. Preadmission List.

o. Projected Dispositions by AFSC/MOS.

p. Register of Patients.

q. Roster of VSI/SI/SC Patients.

r. Status Out Roster.

s. UCA Disposition Report.

t. UCA Inpatient Occupied Bed Days Report.

u. Ward Nursing Report.

4.1.4 Clinical Records Subsystem.

4.1.4.1 Clinical Records Function. Through Clinical Records, final processing on each inpatient episode can be performed and documentation can be produced on dispositioned patients for the patient chart as well as for reporting to higher commands.

This process:

a. Collects, edits, and validates data on each diagnosis made and each surgical procedure performed during the hospital visit.

b. Collects and maintains data on each previous admission to another MTF or civilian hospital.

c. Computes and maintains data on the number of days a patient spent in various clinical services and absent statuses during the inpatient episode.

d. Allows entry of administrative data, and displays and collects codes for physicians associated with this episode.

e. Tracks items missing from the record and posts them as delinquences on the Provider Profile after a period of time specified by the MTF.

f. Initiates final edits on the record and generates the Inpatient Treatment Record Cover Sheet (ITRCS) or Record of Inpatient Treatment (RIPT) and Coded Episode Summary (CES).

g. Produces reports (printouts, report format tapes, archive tapes), including the Coding Transcript.

4.1.4.2 Clinical Records Reports Function. Through this process, users initiate end-of-month processing on records and enter requests to print the following reports, which are described in detail in references listed in paragraphs 1.2b through 1.2g and in the AQCESS Users Manual.

a. Clinical Records Returned to A&D

b. End-of-Month Summary (Navy only)

c. Roster of Delinquent Records

d. Incomplete Inpatient Medical Records Report.

4.1.5 Special Features. The AQCESS will be designed to simplify utilization. It will have many features that will assist the user in entering data quickly and precisely. These features are the:

a. Help Feature. The "HELP" feature will assist the user, on demand, by providing instructions, alternatives, and other assistance for entering data, and producing reports.

b. "T" Feature. The "T" (for today's date) feature will provide current date as a default to avoid the user being required to enter the date. The user can also enter T-1 for yesterday's date, T+30 for the next month, etc.

c. "N" Feature. The "N" feature will permit entering the current date and time. The "N" feature will be used in data/time fields, the "T" feature for date fields.

d. Defaulting Dates. The system will supply default dates as appropriate to the requirement (in some places "today's date," in other places the admission date, or other as needed) to assist in consistent data entry. Except for time stamp purposes, the user will be able to override the date by entering the desired date.

e. Unique Entry Feature. The unique entry feature will allow the user to enter only as much of the field as is necessary to make the entry unique to that field. For example, in the field "Attending Physician," entering WI for Dr. Wilson is sufficient if no other doctor's names begin with WI.

f. Zip Code Feature. Once the street address is entered, the cursor will move directly to the zip code field, where the zip code is entered. The system will then enter the city and state for local (within 100 miles) zip codes. It will also update the zip code table and accommodate the nine-digit zip code.

g. Automatic Text Field Feature. Free-text entry will be provided at required points of data entry without operator request. A default text entry may be provided, which may be overridden by the user. For example, entering the ICD 9 code will result in the display of the corresponding ICD 9 text. The text may be accepted or changed by the user.

4.2 System Functions.

4.2.1 Accuracy and Validity. The System will ensure data accuracy and validity by editing selected input, update, and inquiry data. Data transmitted between internal functions and interfacing systems is subject to the error checks described below.

4.2.1.1 Data Entry Edits. The system shall perform alphanumeric and required field edits on input data and generate appropriate error messages for terminal display.

4.2.1.2 Codes, Predefined Values, and Abbreviations. The system shall accept coded, abbreviated, and other entry values for data items and relate these data to allowable values as defined in the MTF input/edit tables.

4.2.1.3 Consistency Edits. The system will perform defined consistency edits against entered data prior to storing the data in a permanent file. It will notify the user of inconsistencies, and allow rapid, easy correction of erroneous input.

4.2.1.4 Data Transmission. Data transmitted between internal functions and interfacing systems will be subject to error checks including:

a. Internal data element checking of telecommunication data.

b. Internal application checking and acknowledgment by the receiver of telecommunication data.

c. Data set integrity checking of the data base before and after executing backup and failure recovery operations.

4.2.2 Timing.

4.2.2.1 Interactive Search, Interface Interactive Search, Interactive Update, and Interface Interactive Update. The timing requirements for interactive searches and updates are the same as those specified in section 3.1.2.1, Interactive Response Time.

4.2.2.2 Interface Batch Communications. The timing requirements for interface batch communications are the same as those specified in section 3.1.2.2, On Demand Response Time, and section 3.1.2.3, Batch Turnaround.

4.2.2.3 Data Base Response Time. The timing requirements for data base searches are as follows:

a. Data Base Search. The system shall complete a data base search of medium complexity and/or extensiveness and display the first character of the response, reply, or display screen within 4 seconds of its initiation by the user for 85 percent of the cases. Simpler searches and data base activity shall be completed within a 2 second basic response time.

b. Complex or Extensive Data Base Search. Provided that the user realizes (via system message if necessary) that his request is complex and/or large, the system shall complete a complex or extensive data base search and display the first character of the response, reply, or display screen within 10 seconds of its initiation by the user for 80 percent of the cases. A large data base search is defined as a search on multiple fields (FMP/SSN and patient name) in a minimum 100,000 patient data base. A complex and/or extensive search would be a query of (at least) 10,000 active patient records with 10 variables per patient, 1 condition per variable, and 500 matches (hits).

4.2.2.4 Other Specific Response Time Requirements. The following response time requirements shall be met within stated tolerances for the specific special cases to which they refer:

a. Hardware Control Feedback. The system or hardware shall provide positive feedback for user activation of a key on a keyboard, selection of an item from a display, insertion of a badge or card into a reader, and utilization of a bar code, optical character reader (OCR), or optical mark reader (OMR) device within the specified tolerances/variances as follows:

1. Provision of a key click shall always be absolutely within 0.05 seconds of depressing the key in all cases, at the 100th percentile level, with no upward variance.

2. Display of the character produced shall be within 0.05 seconds of depressing the key for a local device, or a "half-duplex" or "local echo" terminal within the specified tolerance/variance.

3. Display of the character produced shall be within twice the above "half-duplex" time for a "full-duplex" or "echo-plex" terminal.

4. Brightening or otherwise indicating a selected "menu" item (when using light pen, touch screen, mouse, or other hardware selection device) shall be within 0.2 seconds.

5. Provision of a click or other indication of correctly positioned badge or card to indicate correct reading of a bar code, OCR code, or OMR code shall be within 0.5 seconds.

b. Screen Fill. The system shall provide for screen fill as follows:

1. Screen-fill time is defined as the time it takes the system to display a complete screen or frame on the user's on-line video terminal device. It is analogous to print-time. Screen-fill time shall be measured as the time from the first character appearing on the user's screen until the last character appears. For purposes of measurement and calculation, a 24 line by 80 column screen may be assumed as a basis, so screen-fill time becomes the time to display 1,920 characters. (This requirement in and of itself does not mandate such a 1,920-character screen; however the requirements herein refer to the assumed standard 24 x 80 screen. If other sized screens are used, they shall be prorated accordingly.) Screen-fill time shall be measurable via a response time monitoring device or, in lengthier cases, by stopwatch.

2. Screen-fill shall be within 2 seconds for local, hardwired, in-house, dedicated, and non-excepted terminals.

c. Display of Next Page. The system fulfillment of a user request to display the next page, screen, or frame of a lengthy or continued display or output shall be within 1 second (for the first character of the next page to appear on the user's terminal device).

d. Sign-On. After entry of appropriate user identification, keywords/passwords, and codes, the system shall complete the sign-on validation and authentication procedure and shall allow the user to begin work within 5 seconds.

e. Confirmation of Acceptance of Complex/Command. The system shall confirm the acceptance of a complex request or command as follows.

1. When a user command or request for processing is of sufficient complexity or extensiveness as to require an extended period of time for processing (i.e., defined as any time greater than the time requirements specified in Section 4.2.2.3), the system shall, within 2 seconds, notify the user that the request or command has been accepted and is now being or will be processed.

2. If the command or request is of such complexity that the system response or reply will not be within the time defined above for interactive processing, then the system shall:

(a) Provide the user with a time estimate of when it may be completed.

(b) Notify the System Manager's console with a request for confirmation to proceed.

(c) When confirmed by the System Manager, perform or process the request in background mode (i.e., off-line) while the user continues with other tasks.

(d) Free the terminal so that the user can continue with further processing.

(e) Notify the user when the request or command is actually completed.

f. Status Query. The system will respond to status queries as follows:

1. When the user requests simple indication of system availability, the system shall respond affirmatively immediately. Failure to respond affirmatively within 2 seconds shall be taken as an indication of a negative (i.e., system unavailable or down) response. This response may be via simple issuing of a normal prompt character of message, or by a specific status reply message.

2. The System Manager may request specific status information on the configuration of the system; a portion of the system or its hardware or software; a task, process, request, or command that has been issued; or on an output that has been initiated. When the System Manager makes such a request, the system shall respond and reply within 3 seconds.

4.3 Flexibility. This section describes the AQCESS external interfaces and security management.

4.3.1 Intersystem Interfaces. The AQCESS will interface to the Defense Enrollment Eligibility Reporting System (DEERS). Other intersystem interfaces will be added to include specified automated PAD card embossers, and ASMRO.

4.3.2 Other Interfaces and Requirements. Other system interfaces and requirements not defined in paragraph 3.2 of this document will be processed as system change requests as stated in Annex M of the TRIMIS Master Plan.

4.4 System Data. The AQCESS produces screen-viewable, hard-copy, and machine-readable reports to meet reporting requirements of the MTF to higher commands. Three types of reports are described here: QA, R/ADT, and Clinical Records. This system will not replace the generation of reports currently produced by higher command reporting systems. It will provide output products to be forwarded to higher commands as inputs to existing reporting systems.

4.4.1 QA Reports.

4.4.1.1 Quality Assurance Subsystem Reports.

a. Blood Utilization Pull List - summarizes blood product utilization, by care provider, over a specified period of time; lists records that are to be reviewed by the Blood Utilization Review Committee.

b. Delinquent Occurrence Screening List - lists all patients whose inpatient occurrence screening checklist is not completed within the period of time after disposition specified by the MTF.

c. Diagnosis Index by Provider - gives information on diagnoses entered in Clinical Records, by provider of care.

d. Dispositions by Diagnosis Report - gives information on diagnoses of patients discharged during the reporting period.

e. Incident Summary - summarizes incidents occurring at the MTF during a specified time period.

f. Occurrence Screening Pull List, Inpatient and Emergency Service - these two reports identify patient records involved in occurrence screening discrepancies, allowing these records to be pulled for review.

g. Occurrence Screening Summaries. These reports summarize occurrence screening data. The inpatient summaries listed below (Facility, Provider, and Specialty) come in two versions. (1) Users can request inpatient summaries containing raw data, which is information on all affirmative responses to checklist items, whether validated or not. Raw data is reported by the primary or responsible provider. Or (2) users can request inpatient summaries containing information only on validated variations; validated data is reported by the provider that the validated variation was posted to.

   1. Facility Occurrence Screening Summary, Inpatient and Emergency Service - summarize affirmative checklist responses for the two checklists. The inpatient summary groups checklist data by the specialty of the patient's physician (if the provider has more than one specialty, the report will show the specialty that relates to this case). The emergency service summary groups data by provider.

   2. Provider Occurrence Screening Summary, Inpatient and Emergency Service - summarize affirmative checklist responses for an individual provider, for a specified period.

3. Specialty Occurrence Screening Summary - summarizes, for affirmative checklist responses for a specified time period, by clinical specialty of the provider. If the provider has more than one specialty, the report will show each specialty and the cases assigned to the doctor in relation to that specialty.

h. Occurrence Screening Suspense List, Inpatient and Emergency Service - these two reports list occurrence screening open items that have been assigned for review and have not been returned.

i. Provider Occurrence Screening Audit, Inpatient and Emergency Service - these two reports list, by provider, all QA actions taken on exceptions to occurrence screening standards.

j. Quality Assurance Problem Audit - presents data about QA problems, either resolved or unresolved.

k. Surgical Index by Provider - gives information on surgical procedures performed during the reporting period.

l. Surgical Operations Report - gives information on surgical procedures performed during the MTF during the reporting period.

4.4.1.2 Profiling Function Reports.

a. Credential Pull List - lists providers by specialty, to facilitate pulling the provider's credential file and performing credential review.

b. Provider Procedure/Mortality Summary - presents the mortality rate for procedures that fall within any of the 26 categories of procedures that are reportable to DoD. It gives one page of mortality statistics for each provider recorded as the primary provider, secondary provider, or teaching assistant involved in performing a procedure that was associated with a patient's death.

c. Provider Procedure Summary - gives mortality information for all procedures performed at the MTF that were associated with a patient death, by providers recorded as primary or secondary provider or teaching assistant.

d. Provider Profile - for individual providers, gives dates for credentials and license renewals, continuing education and certification data. Also shows the following data, where applicable, accumulated for six-month periods: number of procedures performed, patients discharged, malpractice claims filed, medical records deficiencies and delinquencies, and validated complaints, validated variations related to antibiotic use, normal surgical tissue, and transfusions,

validated variations detected through occurrence screening, and total deaths.

e. Providers with Insufficient Continuing Education - lists providers who have fewer credit hours of continuing education than the number entered by the user requesting the report.

4.4.2 A&D (R/ADT) Reports.

a. Admission and Disposition Report - describes all admissions, dispositions, changes of absent status, and newborn activity, as well as corrections to this data. Produced daily, usually at midnight; a partial report can be run on demand.

b. Admission and Disposition Recap/Patient Strength Report - summarizes A&D data by patient category and absent status, and for newborns.

c. Admission Cover Sheet or Admission Form - contains patient identification and admission information on an individual patient. Requested by the user from the Admission or Transfer function.

d. Admission Notification Letters - notify unit commanders of active-duty personnel in their commands whose inpatient admissions were entered in AQCESS on the report date.

e. Admission Summary by Name or Register Number - summarizes all admissions effective in the report month, sorted by patient name or register number.

f. Alpha Roster of Hospital Inpatients - lists all current inpatients, in alphabetical order, showing current ward, clinical service, and absent status, and giving demographic information about each patient. Distributed to A&D Desk to be used as a reference.

g. Command Interest Report - lists all patients by command interest status.

h. Daily Admissions by Diagnosis - gives information about admissions for a given day for each diagnosis, giving demographic data on each admission.

i. Death Report - lists all deaths occurring during the report period, sorted by disposition date and, within date, by name.

j. Disposition Notification Letters (Army only) - notify unit commanders of active-duty enlisted personnel in their commands whose dispositions were entered in AQCESS on the report date.

k. Disposition Summary by Name or Register Number - summarizes all dispositions effective in the report month, sorted by patient name or register number.

l. Index Card (3x5 Card or 5x8 Card) - contains admission data, and is requested by the user from the Admission or Transfer function.

m. Injury Report - lists each patient whose type case indicates injury, and gives demographic data on the patient.

n. Long-Term Patient Roster - lists current inpatients who have been under hospital care for more than the number of days specified at run time; sorted by patient name and, within name, by register number.

o. Patient Charge Roster (Army only) - lists current charges for all inpatients or patients dispositioned on the run date; sorted by patient name.

p. Patient Strength Report - see A&D Recap.

q. Preadmission List - gives data on each current preadmission.

r. Project Dispositions by AFSC/MOS - lists all patients for whom projected dispositions have been entered, sorted by military specialty.

s. Register of Patients - lists the register numbers assigned, with summary patient data, for each day of the report period (can be used in place of DD739).

t. Registration Form - contains registration data on an individual patient. Requested by the user from the Registration function.

u. Roster of VSI/SI/SC Patients - lists, by ward and clinical service, all patients whose casualty code is Very Seriously Ill, Seriously Ill, Special Category, or Terminally Ill. Includes demographic data, diagnosis, and prognosis for each patient.

v. Status Out Roster - lists patients currently out of the hospital, giving their current absent status and expected return date, and indicating whether return is overdue.

w. UCA Disposition Report - gives the number of patients that have been dispositioned during a given month, by UCA Clinical Service code. Produced monthly.

x. UCA Inpatient Occupied Bed Days Report - shows the number of bed days accumulated for each clinical service and ward for a given month. Also shows total bed days per clinical service, total bed days per ward, and a grand total of all bed days for the month. Produced monthly.

y. Ward Nursing Report - alphabetically lists all inpatients currently assigned to each ward, by ward. Gives demographic and admission data on each patient, and includes bed availability data for each ward. Produced daily, usually at midnight.

4.4.3 System Management Outputs. The System Management reports are produced from data entered in System Management or regulated by it. These reports are requested by authorized users from the System Management function (the User ID/Terminal Maintenance Menu).

a. Invalid Sign-On Log - gives information about any incorrect entry of user IDs and passwords. Produced on request of the System Manager, who also specifies the time period of this report.

b. List of Current Passwords - lists the current user IDs and passwords, including the date when these passwords were last changed, and the privileges allowed to each ID-password combination. Produced on request of the System Manager.

4.4.4 Clinical Records Outputs. The outputs described in this section are produced from data retrieved from A&D functions, edited by the Clinical Records subsystem, and supplemented by data entered via the Clinical Records subsystem or calculated by it. The means of requesting each output is specified below.

a. Clinical Records Returned to A&D - lists records that have been returned to A&D for correction. Includes patient identification data, date of disposition, and the reason for the release to A&D. Requested by the user from the Clinical Records Report function.

b. Coded Episode Summary - lists the data included on the Coded Transcript Tape in hard-copy form; contents differ for each military department, as per regulations. Requested by the user from the Clinical Records function.

c. Coded Transcript Tape(s) - a machine-readable report on records that have been processed in the Clinical Records subsystem and approved for inclusion on this tape by the Clinical Records supervisor. Includes final records on patients. The Coded Transcript Tape contains data specified by regulations for each military department. It is requested by the System Manager at the operations console.

d. End-of-Month Summary (Navy use only) - gives summary statistics for all inpatient episodes that are included on the report to higher commands--specifically, on all admissions and dispositions for the month, giving figures for those that have been completely processed in CR and those that are incomplete. Requested by the user from the Clinical Records Report function.

e. Error List - lists any errors in the record that were discovered by Clinical Records edits. Produced automatically after the Coded Episode Summary or the ITRCS/RIPT.

f. Incomplete Inpatient Medical Records Report - lists incomplete records of patients, by the provider responsible for the missing item(s).

g. Inpatient Treatment Record Cover Sheet or Record of Inpatient Treatment (ITRCS/RIPT) - contains data on an individual inpatient episode that has been accessed in Clinical Records. Requested by the user from the Clerk Actions Screen.

h. Roster of Delinquent Records - lists records that have not been completely processed in Clinical Records within the time limit set by the MTF, and which are therefore delinquent. Requested by the user from the Clinical Records Report function.

SECTION 5. ENVIRONMENT

5.1 Equipment Environment. The system will be based on small (micro/mini) computers. each system will have the capability to adequately fulfill the AQCESS requirements. The central processing unit (CPU) will most likely be installed in the PAD or QA area requiring no major structural enhancements. The system will operate in a normal office environment (60°-90° F) with no dedicated air conditioning or raised flooring required.

5.2 Support Software Environment. All application programs will be designed and written in a modular, structured, top-down fashion, the inherent character of each module being a stand-alone program only requiring initiation, to be processed. All modules will be written in 1983 Draft ANSI x 11.1-1977 MUMPS including compliance with "NEW" command as specified in 1983 Type A Release of the MUMPS Development Committee, allowing transportability from computer to computer without modifications or module rewrites. All operating system software will be fully supported by the vendor supplying the equipment, to include periodic updates to the system software as they become available.

5.3 Interfaces. The application software will interface with at least one currently operational system, DEERS. The system may be interfaced with existing COBOL PAD systems depending on the method chosen to satisfy Business' Office requirements. Additional interfaces to standard automated embossing machines will be specified. Interfaces will be designed to conform to the accepting system technology and provide information in the form necessary.

5.4 Summary of Impacts. MTF automation management organizations will not be affected unless the MTF chooses to install the hardware in the ADP area instead of a functional work environment. If this situation occurs, minor impact to the ADP organization would be a requirement for space in their computer rooms, less than 100 square feet, and the requirement for an occasional check on the computer by an on-board employee.

5.4.1 ADP Organization Impacts. The ADP organizations will not notice any major change if the hardware is installed in their computer rooms. The MTFs that choose to install the equipment in a functional work area will impose no impact on the ADP environment or organization.

5.4.2 ADP Operational Impacts. If the MTF elects to install the equipment in the ADP area, minimum impact will occur. The operational staff will be ex-

pected to monitor the activity of the AQCESS computer as required. There will be a requirement for the staff to distribute output reports daily. This should not consume more than 30 minutes for one employee per day.

5.4.3 ADP Development Impacts. The MTF's automation directorates' programming staff will have no responsibilities for the development or maintenance of the QA application software or the operating system.

The initial software installation will be performed by the TRIMIS software software support contractor personnel at all sites. The application software will be developed and maintained by the originating contractor or the current TPO software support contractor personnel.

5.5 Failure Contingencies. The hardware will include a backup data storage device as part of the total system. This device will be utilized as required to back up the data base. In case the data base integrity is destroyed inadvertently or the primary mass storage device malfunctions and must be reconstructed, this technique will protect the facility from extensive data losses.

Equipment maintenance will be ongoing for all hardware installed in each MTF. Preventive maintenance and care will be performed on equipment according to the manufacturers' recommended schedules.

The system should allow adequate time to bring the application system and hardware to a smooth and orderly shutdown until power is restored. Contingency routines will be built into the application software to provide ease of data protection and restoration. Simple procedure manuals will be supplied and instructional training will be provided during each site implementation.

It is desirable that the System Manager have the capability to transmit free-text messages (minimum of 1 line) form the operations console or terminal to all or selected users. The message may overwrite the user's current screen contents or appear at the top/bottom. A loss of data being entered by the user at the time of the message will be an absolute minimum.

5.6 Security.

5.6.1 Privacy. The privacy considerations, as enacted by the Privacy Act of 1974, Public Law 93-579 (effective 27 September 1975) and amended/amplified by subsequent laws and directives, will be considered in the use of this information processing system. The MTFs will comply with all applicable provisions of these acts and regulations. The application software will have security and privacy safeguards built in. These precautionary procedures will be created to provide sensitive input and output with the highest level of confidentiality available to the maximum limits of the hardware and software cap-

abilities. The comprehensive security system will provide for individual user identification, restricted access to patient files and data, user time-outs, on terminals, and definite verification of patient identification. The system's software security will be maintained by the originating vendor. The individual MTFs will not have local capability to effect changes in the operating system, application software, transaction processor, or other system support software.

5.6.2 System Security and Privacy. System components requiring security and privacy measures are computer programs, inputs, data bases, outputs, as well as the system hardware. The security and privacy measures described in the following paragraphs must fulfill all mandatory security and privacy requirements without unduly affecting system efficiency.

5.6.2.1 Security and Privacy. Protection requirements for National Security Information, as established by Executive Order 11652 of 8 March 1972, must be considered in the use of all information processing systems. DoD policies and considerations for protecting classified National Security Information stored or processed by automatic data processing systems are contained in DoD Directive 5200.28 of 18 December 1972 and in DoDD 5200.28-M of January 1973. Privacy considerations, as enacted by the Privacy Act of 1974, Public Law 93-579 (effective 27 September 1975) and amended/amplified by subsequent laws and directives, must be considered in the use of all information processing systems. This Act is implemented by DoD Directive 5400.11 of 4 August 1975. The system will comply with applicable provisions of these acts and regulations.

5.6.2.2 System Software Security. System software security shall be maintained through TRIMIS central control of modifications to system software. This process will be controlled as specified in Annex M of the AQCESS Master Plan. Individual MTFs shall not have local capability to effect changes in the system's operating system, application software, transaction processor, or other system support software.

5.6.2.3 Input Security. Terminal input security shall be assured by limiting the users of the terminal. Each authorized user shall be assigned a unique identification code. This code must be entered into the terminal and subsequently verified by the system before any other terminal functions can be performed. Once a user has entered the system, access shall further be limited to only those functions for which a user has authorization. The system shall have the functional capability to maintain a table of authorized users and their passwords. In addition, the System Manager shall control the functions a given terminal may perform (e.g., the System Manager could prevent any user, no matter what functional access authorized, from displaying patient data in a public area).

5.6.2.4 Security and Privacy of Internal Data. Security and privacy of the data bases, or data internal to the system, shall be effected through controls at various levels of the system software. These controls shall include user sign-on and access security routines that prevent the use of terminals by unauthorized users for inappropriate functions.

The System Administrator shall have the capability to create and maintain (add, change, or delete) a table of the following:

a. Authorized terminal operators.

b. Unique identification codes for each terminal operator.

c. Task streams that each terminal operator has authority to perform.

5.6.2.5 Security and Privacy of Output. Security and privacy of output shall be provided as follows:

a. Access to CRT displays shall be controlled through the terminal operator code and associated authorized task tables. The system shall provide a feature that allows the MTF to designate the number of minutes a terminal screen display will remain in view. The system shall automatically clear the screen after the designated time has elapsed to avoid leaving privileged information on the screen for unauthorized review. The current user will then be logged off.

b. Printed reports containing restricted data shall have the required leading and trailing statements on each page reflecting document security level and required handling (i.e., Privacy Act data and/or QA data which is non-releasable). Reports printed on a terminal printer shall be subject to the same access security criteria as data used to create a CRT display.

c. Security procedures for distributing printed reports shall be governed by current DoD and Service regulations and individual MTF policies and procedures.

d. System archive and backup data sets shall be subject to existing storage and security regulations. Specifically, these types of data should be maintained in secure facilities that are geographically removed from the operational AQCESS configuration.

5.6.2.6 Physical Security. Central hardware configuration component security shall be assured by establishing limited access for personnel to the area containing the hardware. This limited access may be effected through the use of cypher locks or other access control devices. Security-surveillance monitoring and control techniques must be employed as specified in Military Depart-

ment regulations. The MTF will be responsible for securing system components during non-duty hours.

5.6.2.7 Distribution Procedures. Security procedures for distributing printed reports shall be governed by current DoD and Service regulations and by individual MTF policies and procedures.

5.7 Assumptions and Constraints. The application software must be written in ANSI MUMPS to allow for transportability, simplicity, and ease of design. All hardware configurations, regardless of their size, will be capable of processing in the same (identical) software environment. Existing Government-owned MUMPS PAD software will be used as the basis on which to develop the QA system.

SECTION 6. COST FACTORS. Maintained by the TRIMIS Program Office.

SECTION 7. SYSTEM DEVELOPMENT PLAN. Refer to the RFP.

APPENDIX A

DATA BASE CHARACTERISTICS

INPUTS

Function	Subfunction	Input Abbr*	Input Data Elements
Quality Assurance	Occurrence Screening	POSC	Date Entered Register Number Patient Name FMP/SSN Discharge Date Provider ID Occurrence Criterion Occurrence Description Y/N Indicator
		PESOSC	Print Option Date Entered Patient Name FMP/SSN Date of Treatment Provider ID Occurrence Criterion Occurrence Description Y/N Indicator Print Option Provider ID
	Incident Reporting	IR	Log # Date Occurred Time Occurred Person Involved Incident Type of Incident Personnel Involved/Reporting Incident Result of Incident Date Received by Risk Manager JAG Review Date Sent to JAG Date of Action Action Code Print Option

INPUTS

Function	Subfunction	Input Abbr*	Input Data Elements
Quality Assurance	Problem Audit Tracking	QAPA	Date Number Date Presented Referral Activity Impact on Patient Care Action Activity Status Date Action Taken Follow-up Date Print Option
	Blood Utilization		System extracts from coding transcript

INPUTS

Function	Subfunction	Input Abbr*	Input Data Elements
Quality Profiling		PP	Date Entered Provider ID Provider Name Provider Specialty Date of CPR Training Date of ACLS Certification Date of ATLS Certification Date of License Renewal Date of Credentials Renewal State of License Totals of Procedures Performed Totals of Surgical Patients with Normal Tissue (Failed Criteria Totals of Medical Record Deficiences Totals of Medical Record Delinquencies Totals of Patients Discharged Totals of Validated Occurrence Screening Variations Totals of Transfusion Variations (Failed Criteria) Totals of Antibiotic Variations (Failed Criteria) Totals of Malpractice Claims Filed Print Option
		PMPRC	Date Entered Provider ID Provider Name Provider Specialty Procedure Code Comment

OUTPUTS

Function	Subfunction	Input Abbr*	Input Data Elements
Quality Assurance	Occurrence Screening	POSS	Date Prepared Provider ID Period Number of Records Screened Occurrences by Criterion Number (Initial Review) Total Occurrences Total Provider Occurrences
		SOSS	Date Prepared Specialty Period Provider ID Number of Records Screened Occurrences by Criterion Number (Initial Review) Total Provider Occurrences Total Specialty Occurrences
		FOSS	Date Prepared Specialty Period Provider ID Number of Records Screened Occurrences by Criterion Number (Initial Review) Total Provider Occurrences Total Specialty Occurrences
		PESOSS	Date Prepared Specialty Period Provider ID Number of Records Screened Occurrences by Criterion Number Total Occurrences
		FESOSS	Date Prepared Specialty Period Provider ID Number of Records Screened Occurrences by Criterion Number Total Occurrences

OUTPUTS

Function	Subfunction	Input Abbr*	Input Data Elements
			Total Number of Records Screened
			Total Occurrences by Criterion Number
			Total Provider Occurrences
		POSA	Date Prepared
			Provider ID
			Period
			Reg. Number
			Discharge Date
			Occurrence Criterion
			Occurrence Description
			Review Number
			Date Out
			Date Due
			Date In
			Action Code
			Total Occurrences Screened
			Total Second Level Review
			Total Third Level Review
			Total Occurrences Entered into Provider File.
			Print Option
		PESOSA	Date Prepared
			Period
			Provider ID
			Date of Treatment
			Occurrence Criterion
			Occurrence Description
			Review Number
			Date Out
			Date Due
			Date In
			Action Code
			Total Occurrences Screened
			Total Second Level Review
			Total Third Level Review
			Total E.S. Occurrences Failed Criteria
			Print Option
		OSPL	Date Prepared
			Reg. Number
			FMP/SSN
			Occurrence Criterion

OUTPUTS

Function	Subfunction	Input Abbr*	Input Data Elements
		OSSL	Date Prepared Discharge Date Date Out Action Code
		ESOSSL	Date Prepared Register Number Date of Treatment Review Level Date Out Action Code
		DOSL	Date Prepared Discharge Date Register Number FMP/SSN
	Incident Reporting	IS	Date Prepared Sort Key Log # Incident Date Incident Time Type Person Involved Type of Incident Location of Incident Category of Person Reporting

OUTPUTS

Function	Subfunction	Input Abbr*	Input Data Elements
			Category of Person Involved
			Injury
			Action Code
			JAG Review
	Problem Audit Tracking	QAPA	Date
			Number
			Date Presented
			Referral Activity
			Impact on Patient Care
			Action Activity
			Status Date
			Action Taken
			Follow-up Date
			Print Option
	Blood Utilization	BUPL	Date Prepared
			Period
			Provider ID
			Register Number
			FMP/SSN
			Discharge Date
			Number of Units Transfused
			Comment

OUTPUTS

Function	Subfunction	Input Abbr*	Input Data Elements
Provider Profiling	Provider Profiling	PP	Date Entered Provider ID Provider Name Provider Specialty Date of CPR Training Date of ACLS Certification Date of ATLS Certification Date of License Renewal Date of Credentials Renewal State of License Totals of Procedures Performed* Totals of Surgical Patients with Normal Tissue (Failed Criteria Totals of Deaths (Failed Criteria Totals of Medical Record Deficiencies* Totals of Medical Record Delinquencies* Totals of Patients Discharged* Totals of Validated Occurrence Screening Variations Totals of Transfusion Variations (Failed Criteria) Totals of Validated Patient Complaints Totals of Antibiotic Variations (Failed Criteria) Totals of Malpractice Claims Filed Print Option

Note: Data marked with an * will be provided by the system. Other data will be provided by the appropriate committees, i.e., normal tissue by the Tissue Committee.

OUTPUTS

Function	Subfunction	Input Abbr*	Input Data Elements
	Provider Procedures/ Mortalities Summary	PP/MS	Date Prepared Period Provider ID Procedure Code Procedure Text Total Procedures Performed Total Deaths Mortality Rate Rate Criterion Peer Review Comments
		CPL	Date Prepared Period Provider ID Specialty Date Required
		PPS	Date Prepared Provider ID Period Procedure Code Procedure Text Total Procedures Performed Total Deaths Mortality Rate

APPENDIX B

LIST OF PROPOSED SCREENS

Administrative Data Screen
Admission·Cancellation Screen
Authorized Functions
Bed Management Screen
Blood Utilization Pull List
CRID Screen
Candidate List Screen
Clerk Actions Screen
Clerk Screen
Credential Pull List
Diagnosis Screen
Episode Days by Clinical Service Screen
Episode Days by Date Screen
Facility Emergency Service Occurrence Screening Summary
Facility Occurrence Screening Summary
Incident Report
Incident Summary
Inpatient History Candidate List Screen
Inpatient History Screen
MTF Profile Maintenance Screen
Main Menu
Menu Screen
Miscellaneous Screen
Non-Procedural Providers Screen
Occurrence Screening Pull List
Outpatient Products Screen
Patient Identification (PTID) Screen
Primary Admission Screen
Primary Disposition Screen
Primary Registration Screen
Procedure Screen
Provider Emergency Service Occurrence Screening Checklist
Provider Emergency Service Occurrence Screening Summary
Provider Emergency Service Occurrence Screening Audit
Provider Occurrence Screening Summary
Provider Occurrence Screening Audit
Provider Procedures/Mortalities Summary
Provider Profile
Provider Profiling Subsystem Menu
Quality Assurance Problem Audit
R/ADT Report Selection Screen

Record Tracking Screen
Register Number Maintenance Screen
Registration History Screen
Reports Menu
Sample Screen
Screen Format
Sign On
Sign-on Screen
Specialty Occurrence Screening Summary
Standard Data Fields and CR Menu
System Management Menu
Table List Menu Screen
Transfer History Screen
User Access Menu Screen

APPENDIX C

NORMS FOR 26 SURGICAL PROCEDURES IN MEDICAL TREATMENT FACILITIES (mtfs)

Procedure	ICP Codes	Normal Percentage
Caesarian Section, All	5740-42,48,49	*2
Dilatation and Curettage	5690	*
Repair, Inguinal/Femoral Hernia	5530-33	*
Tubal Ligation	5664	*
Laparotomy	5541	20
Appendectomy	5470,71,79	*
Tonsillectomy and/or Adenoidectomy	5281-89	*
Open Reduction of Fracture	5791-92	*
Cholecystectomy	5511	3
Abdominal Hysterectomy	5682-83	*
Vaginal Hysterectomy	5682	*
Thoracotomy	5340	25
Transurethreral Resection, Prostate (TURP)	5601	*
Salpingo-oophorectomy	5653,55	*
Excision Intervertebral Disc	5803	*
Excision Similunar Cartilage, Knee	5804	*
Extraction, Intraocular Lens	5142-46	*
Thyroidecotomy, All	5061-64	*
Mastectomy, All	5861-65	*
Colectomy, Partial	5455	15
Arthroplasty, Knee	5814	*

Procedure	ICP Codes	Normal Percentage
Repair, Hernia, Abdominal Wall	5535	*
Transurethral Resection	5573	*
Endarterectomy	5381	3
Bypass Anastamosis, Heart	5361	10
Craniotomy	5011	20

* Means less than 1.0 Percent. Too low for valid statistical analysis for individual providers. Any death under these procedures must be reviewed.

APPENDIX D

DATA DICTIONARY

DATA ELEMENT NAME: Activity

DEFINITION: A free-text field to identify the MTF activity assigned responsibility for resolution of the problem.

LENGTH: 15 **CLASSIFICATION:** A/N

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** QAPA

****

DATA ELEMENT NAME: Action Code

DEFINITION: See Appendix E, AQCESS FD, for values for each digit of this code. A manually entered shortened version of Activity Action.

LENGTH: 4 **CLASSIFICATION:** A/N

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** IR, IS, POSA, PESOSA, OSSL ESSOSL

****

DATA ELEMENT NAME: Action Taken

DEFINITION: A free-text field indicating final resolution of the problem.

LENGTH: 80 **CLASSIFICATION:** A/N

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** QAPA

****

DATA ELEMENT NAME: Comment

DEFINITION: A column heading only. Space will be used for manual remarks on hard copy.

LENGTH: 7 **CLASSIFICATION:** ALPHA (Value "Comment")

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** PMPRC, BUPL

****

DATA ELEMENT NAME: Date

DEFINITION: A DoD standard representing year, month, and day a particular report was generated. Format is YYMMDD.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** QAPA

****

DATA ELEMENT NAME: Date Due

DEFINITION: The year, month, and day (YYMMDD) the review of an occurrence is due back to the MTF QAC.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** POSA, PESOSA

****

DATA ELEMENT NAME: Date Entered

DEFINITION: The year, month, and day (YYMMDD) the appropriate screen information was input to the system. This is system generated.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** POSC, PESOSC, PP, PMPRC

****

DATA ELEMENT NAME: Date In

DEFINITION: The year, month, day (YYMMDD) an occurrence review is actually received back into the QA office.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** POSA, PESOSA

****

DATA ELEMENT NAME: Date Occurred

DEFINITION: The date (YYMMDD) an incident occurred. Input by the user to Section I.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** IR

****

DATA ELEMENT NAME: Date of ACLS Certification

DEFINITION: The last date (YYMMDD) of a provider's Advanced Cardiac Life Support (ACLS) certification.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** PP

****

DATA ELEMENT NAME: Date of Action

DEFINITION: The date (YYMMDD) associated with the Action-Code of an incident.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** IR

****

DATA ELEMENT NAME: Date of ATLS Certification

DEFINITION: The last date (YYMMDD) of a provider's Advanced Trauma Life Support (ATLS) certification.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** PR

****

DATA ELEMENT NAME: Date of CPR Training

DEFINITION: The date (YYMMDD) the provider last passed the cardiopulmonary resuscitation test.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** PP

****

DATA ELEMENT NAME: Date of Credentials Renewal

DEFINITION: The date (YYMMDD) the health provider's credentials were last verified/renewed.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** PP

****

DATA ELEMENT NAME: Date of License Renewal

DEFINITION: The date (YYMMDD) the provider's medical license was last issued or renewed.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** PP

****

DATA ELEMENT NAME: Date of Treatment

DEFINITION: The year, month, day a patient's episode occurred in the MTF's emergency services.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** PESOSC, PESOCA

****

DATA ELEMENT NAME: Date Out

DEFINITION: The date an occurrence was sent from the QA Office for first, second, or third level review. YYMMDD format.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** POSA, PESOSA, OSSL, ESOSSL

****

DATA ELEMENT NAME: Date Prepared

DEFINITION: The machine-generated date of the report, in YYMMDD format. resusitation test.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** POSS, SOSS, FOSS, PESOSS, FESOSS, POSA, PESOSA, OSPL, IS, DOSL, BUPL, PP/MS, CPL, PPS, OSSL, ESOSSL

****

DATA ELEMENT NAME: Date Presented

DEFINITION: The date (YYMMDD) a QA problem was referred to an MTF activity for resolution.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** QAPA

****

DATA ELEMENT NAME: Date Received by Risk Manager

DEFINITION: The date the incident was received in the MTF's Risk Management Office. This is input by the user to Section VII of the Incident Report.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** IR

****

DATA ELEMENT NAME: Date Required

DEFINITION: Calculated by the system by adding 24 months to the "Date of Credentials Renewal" from the PP. Format is YYMMDD.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** CPL

****

DATA ELEMENT NAME: Date Sent to JAG

DEFINITION: The date (YYMMDD) an incident report was sent to JAG for review. Input by user to the Incident Report.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** IR

****

DATA ELEMENT NAME: Discharge Date

DEFINITION: The year, month, day (YYMMDD) a patient was dispositioned from the facility.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: R/ADT **FUNCTION/SUBFUNCTION UTILIZATION:** OSSL, ESOSSL

****

DATA ELEMENT NAME: Enter Selection

DEFINITION: A prompt by the system for the user to enter the appropriate selection code for an option on the menu.

LENGTH: 1 **CLASSIFICATION:** A/N

OWNERSHIP: SM **FUNCTION/SUBFUNCTION UTILIZATION:** Menu Screens

****

DATA ELEMENT NAME: FMP/SSN

DEFINITION: Family Member Prefix is a 2-digit numeric integer prefixed to the service member's Social Security Number to identify which family member is being treated.

LENGTH: 11 **CLASSIFICATION:** NUM-INT

OWNERSHIP: R/ADT **FUNCTION/SUBFUNCTION UTILIZATION:** DOSL, POSA
POSC

****

DATA ELEMENT NAME: Follow-Up Date

DEFINITION: The year, month, day any follow-up action occurred for a QA problem.

LENGTH: 6 **CLASSIFICATION:** N

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** QAPA

****

DATA ELEMENT NAME: Impact on Patient Care

DEFINITION: A free-text description of the problem.

LENGTH: 160 **CLASSIFICATION:** A/N

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:**

****

DATA ELEMENT NAME: Incident Date

DEFINITION: The date (YYMMDD) an incident occurred. Date gathered from Section I of IR.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** IS

****

DATA ELEMENT NAME: Incident Time

DEFINITION: The time (9999 Hrs) an incident occurred using a 24-hour clock. Time gathered from Section I of IR.

LENGTH: 4 **CLASSIFICATION:** NUM-INT

OWNERSHIP: SM **FUNCTION/SUBFUNCTION UTILIZATION:** IS

****

DATA ELEMENT NAME: JAG Review

DEFINITION: A one-alphabetic character, yes/no indicator as to whether or not this incident should be reviewed by the local Judge Advocate General's office. Input by the user in Section VII B. of the IR.

LENGTH: 1 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** IR, IS

****

DATA ELEMENT NAME: MTF

DEFINITION: Acronym for Medical Treatment Facility. A hospital or medical clinic which provides health care services.

LENGTH: 24 **CLASSIFICATION:** A/N

OWNERSHIP: CR **FUNCTION/SUBFUNCTION UTILIZATION:**

****

DATA ELEMENT NAME: Mortality Rate

DEFINITION: The percentage of deaths by procedure performed. This rate is calculated by the system by summing the total deaths within a procedure code, and dividing by total number of those procedures performed.

LENGTH: 4 **CLASSIFICATION:** NUM/INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** PP/MS, PPS

****

DATA ELEMENT NAME: Number

DEFINITION: The total of some entity, i.e., the number of records processed. Calculated by N + 1 (N being the previous total).

LENGTH: 3 **CLASSIFICATION:** NUM-INT

OWNERSHIP: CR **FUNCTION/SUBFUNCTION UTILIZATION:** QAPA

****

DATA ELEMENT NAME: Number of Records Screened

DEFINITION: The total number of records screened by the system for a period of time. Used by both emergency service and inpatient summaries.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** PESOSS, FESOSS

****

DATA ELEMENT NAME: Number Units Transferred

DEFINITION: The number of units of blood which were actually infused into the patient.

LENGTH: 2 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** BUPL

****

DATA ELEMENT NAME: Occurrence by Criterion Number

DEFINITION: The number of times a particular occurrence appeared within a user-specified period of time. Used by both inpatient and emergency service reports. On inpatient reports it indicates initial review level only. It's calculated by the system based on the number of Y and N answers on the check-list. Count is N + 1.

LENGTH: 3 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** POSS, FOSS, SOSS, SOSS, PESOSS, FESOSS

****

DATA ELEMENT NAME: Occurrence Criterion

DEFINITION: The number attached to a specific occurrence.

LENGTH: 2 **CLASSIFICATION:** A/N

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** POSC, PESOSC, POSA, PESOSA, OSPL

****

DATA ELEMENT NAME: Occurrence Description

DEFINITION: The textual description of an occurrence criterion.

LENGTH: 160 **CLASSIFICATION:** A/N

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** POSC, PESOSC, POSA, PESOSA

****

DATA ELEMENT NAME: Password

DEFINITION: User private key to gain authorized entry to the system. Maintained by System/Security Manager.

LENGTH: 9 **CLASSIFICATION:** A/N

OWNERSHIP: SM **FUNCTION/SUBFUNCTION UTILIZATION:** System Access Screen

****

DATA ELEMENT NAME: Patient Name

DEFINITION: The complete legal name of a patient including any additional abbreviations or numerals.

LENGTH: 27 **CLASSIFICATION:** ALPHA

OWNERSHIP: R/ADT **FUNCTION/SUBFUNCTION UTILIZATION:** POSC, PESOSC

****

DATA ELEMENT NAME: Peer Review Comment

DEFINITION: The free-text comments (up to 160 characters per procedure) that the peer review committee writes on the PMPRC regarding the mortalities per procedure. The text is entered into the system for inclusion in the PP/MS.

LENGTH: 160 **CLASSIFICATION:** A/N

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** PMPRC, PP/MS

****

DATA ELEMENT NAME: Period

DEFINITION: The length of time to be covered by a report. User entered when selecting the report for production. Format is YYMMDD-YYMMDD.

LENGTH: 13 **CLASSIFICATION:** A/N

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** PPS, CPL, PP/MS, BUPL, PESOSA, POSA, FESOSS, PESOSS, FOSS, SOSS, POSS

****

DATA ELEMENT NAME: Procedure Code

DEFINITION: Four-digit ICP code representing a specific surgical procedure. It can have a 2-digit alphanumeric suffix assigned to it.

LENGTH: 6 **CLASSIFICATION:** A/N

OWNERSHIP: CR **FUNCTION/SUBFUNCTION UTILIZATION:** PMPRC, PP/MS, PPS

****

DATA ELEMENT NAME: Procedure Text

DEFINITION: Identifies a specific clinical care service/test/procedure, including both broad and specific classifications of procedures (e.g. surgical incision). May be input as a four-digit ICP code or as nine-digit mnemonic. (ICP is the International Classifications of Procedures.) The actual text is taken from the stub file of ICP codes which is already in TRIPAD.

LENGTH: 64 **CLASSIFICATION:** A/N

OWNERSHIP: R/ADT **FUNCTION/SUBFUNCTION UTILIZATION:** PP/MS, PPS

****

DATA ELEMENT NAME: Provider Identification (ID)

DEFINITION: A unique code identifying a member of the health care team providing health service to a patient.

LENGTH: 12 **CLASSIFICATION:** A/N

OWNERSHIP: CR **FUNCTION/SUBFUNCTION UTILIZATION:** POSC, PESOSC, PP, PMPRC, POSS, SOSS, FOSS, PESOSS, FESOSS, POSA, PESOSA, BUPL, PP/MS, PPS

****

DATA ELEMENT NAME: Provider Name

DEFINITION: The full name of a member of the health care team providing health service to the patient. The format is a DoD standard.

LENGTH: 27 **CLASSIFICATION:** ALPHA

OWNERSHIP: CR **FUNCTION/SUBFUNCTION UTILIZATION:** CPL, PP, PMPRC

****

DATA ELEMENT NAME: Provider Specialty

DEFINITION: A code which specifies a health care provider's specialty field(s) of medical practice (e.g., neurology, cardiology, pediatrics).

LENGTH: 6 **CLASSIFICATION:** A/N

OWNERSHIP: CHCS **FUNCTION/SUBFUNCTION UTILIZATION:** PP, PMPRC

****

DATA ELEMENT NAME: Rate Criterion

DEFINITION:

LENGTH: 2 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** PP/MS

****

DATA ELEMENT NAME: Referral Activity

DEFINITION: A free-text identification of the activity in the MTF that identified the source of the problem.

LENGTH: 15 **CLASSIFICATION:** A/N

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** QAPA

****

DATA ELEMENT NAME: Register Number

DEFINITION: The unique number assigned to each inpatient record to identify a hospital episode in which clinical care services are received. A new register number is assigned for each hospitalization.

LENGTH: 8 **CLASSIFICATION:** NUM-INT

OWNERSHIP: R/ADT **FUNCTION/SUBFUNCTION UTILIZATION:** POSA, OSPL, DOSL, BUPL, POSC

****

DATA ELEMENT NAME: Review Level

DEFINITION: The level of review that could take place before an occurrence is resolved. Values are 1, 2 or 3.

LENGTH: 1 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** POSA, FESOSA, OSSL, ESOSSL

****

DATA ELEMENT NAME: Sort Key

DEFINITION: The first 12 characters of the data element name selected to determine the sort order of the report, as well as appearing as the left-most column of the report. Input is by the user when prompted by the system.

LENGTH: 12 **CLASSIFICATION:** A/N

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** IS

****

DATA ELEMENT NAME: Specialty

DEFINITION: Specifies an HCP special field of medical practice, e.g., neurology, cardiology, pediatrics.

LENGTH: 6 **CLASSIFICATION:** A/N

OWNERSHIP: CR **FUNCTION/SUBFUNCTION UTILIZATION:** SOSS, FOSS, PESOSS, FESOSS, CPL

****

DATA ELEMENT NAME: State of License

DEFINITION: State in which a health care provider's license is issued.

LENGTH: 2 **CLASSIFICATION:** ALPHA

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** PP

****

DATA ELEMENT NAME: Time Occurred

DEFINITION: The time of day, in 24-hour clock format, that an incident occurred.

LENGTH: 4 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** IR

****

DATA ELEMENT NAME: Time of Incident

DEFINITION: Same as Time Occurred.

LENGTH: 4 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** IS

****

DATA ELEMENT NAME: Total Deaths

DEFINITION: The total number of deaths of patients by procedure code, per health provider. Count is N + 1. This total is used in the calculation of mortality rate for a provider.

LENGTH: 2 **CLASSIFICATION:** NUM-INT

OWNERSHIP: CR **FUNCTION/SUBFUNCTION UTILIZATION:** PP/MS, PPS

****

DATA ELEMENT NAME: Total E.S. Occurrences Failed Criteria

DEFINITION: If an occurrence review goes all the way through the third level and the provider is held accountable for the occurrence, it is entered into the provider's file, and assigned an appropriate action code. This data element is a sum (N + 1) of those action codes within a specified period of time.

LENGTH: 2 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** PESOSA

****

DATA ELEMENT NAME: Total Facility Occurrences

DEFINITION: The system-calculated sum (N + 1) of total occurrences in the MTF.

LENGTH: 5 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** FOSS

****

DATA ELEMENT NAME: Total Occurrences

DEFINITION: The total number of provider, department, or facility occurrences answered yes on the checklist for a period of time. This total may appear on reports for inpatient episodes as well as emergency service encounters.

LENGTH: 5 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** FESPSS. PESOSS, POSS, SOSS, FOSS

****

DATA ELEMENT NAME: Total Occurrences by E.S. Criterion Number

DEFINITION: The system-calculated sum of each emergency service occurrence criterion column.

LENGTH: 4 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** FESOSS

****

DATA ELEMENT NAME: Total Occurrences by Facility

DEFINITION: The total of the Total Occurrences column for the Facility Occurrence Screening Summaries (both hospital-wide and emergency services).

LENGTH: 9 **CLASSIFICATION:** NUM-INT

OWNERSHIP: **FUNCTION/SUBFUNCTION UTILIZATION:** FOSS, FESOSS

****

DATA ELEMENT NAME: Total Occurrences Entered Into Provider Profile

DEFINITION: This is a number computed by the system by counting (N + 1) the specific action codes indicating an occurrence was entered into a provider's file. This total gets forwarded through the system to the POSS data base for permanent storage.

LENGTH: 5 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** POSA

****

DATA ELEMENT NAME: Total Occurrences Screened

DEFINITION: The total number of occurrences screened from the checklists to produce the data for the inpatient or emergency service audits. Count is N + 1.

LENGTH: 9 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** POSSA, PESOSA

****

DATA ELEMENT NAME: Total of Records Screened

DEFINITION: The sum of the Number of Records Screened column on the MTF-level Emergency Service Occurrence Screening Summary.

LENGTH: 6 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** FESOSS

****

DATA ELEMENT NAME: Total Procedures Performed

DEFINITION: The total number of the type of procedure performed by a provider. Count is N + 1. Information is calculated from entries on the CRCT.

LENGTH: 3 **CLASSIFICATION:** NUM-INT

OWNERSHIP: CR **FUNCTION/SUBFUNCTION UTILIZATION:** PP/MS, PPS

****

DATA ELEMENT NAME: Total Provider Occurrences

DEFINITION: The system-calculated sum, by criterion by provider, for a specialty of Y or N counts (N + 1) on the checklist.

LENGTH: 5 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** POSS, SOSS
FOSS, FESOSS

****

DATA ELEMENT NAME: Total Second Level Reviews

DEFINITION: The sum of each occurrence criterion which has an action code entry indicating a second-level review has occurred of emergency service or inpatient episode occurrences. Count N + 1. Calculated by the system.

LENGTH: 5 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** POSA, PESOSA

****

DATA ELEMENT NAME: Total Specialty Occurrences

DEFINITION: The system-calculated sum by provider of Y or N counts (N + 1) on the checklists.

LENGTH: 5 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** SOSS

****

DATA ELEMENT NAME: Total Third Level Review

DEFINITION: The sum of each occurrence criterion which has an action code entry indicating a third level review has occurred of emergency service or in-patient episode occurrences. Count is N + 1 and is calculated by the system.

LENGTH: 5 **CLASSIFICATION:** NUM-INT

OWNERSHIP: QA **FUNCTION/SUBFUNCTION UTILIZATION:** POSA, PESOSA

****

DATA ELEMENT NAME: User Identification

DEFINITION:

LENGTH: 9 **CLASSIFICATION:** A/N

OWNERSHIP: SM **FUNCTION/SUBFUNCTION UTILIZATION:**

****

DATA ELEMENT NAME: **Yes/No Indicator**

DEFINITION: **A Y or N indicator entered by the user at system request to print a screen, or select a menu option, or indicate whether an occurrence was present on the checklists.**

LENGTH: **1** CLASSIFICATION: **ALPHA**

OWNERSHIP: **QA** FUNCTION/SUBFUNCTION UTILIZATION: **PESOSC, POSC**

****

APPENDIX E

PROVIDER OCCURRENCE SCREENING AUDIT AND

PROVIDER EMERGENCY SERVICE OCCURRENCE SCREENING AUDIT

ACTION CODE TABLE

First Digit (Referred To)

A. Credentials Committee
B. Blood Utilization Committee
C. Therapeutic Agents Board
D. Tissue Committee
E. Infection Control Committee
F. Risk Manager
G. Commander
H. Chief of Service
I. Graduate Medical Education
J. Executive Committee
K. Quality Assurance Committee
L. Quality Assurance Coordinator
M-Z. Other, locally assigned

Second Digit

1. Provider Related
2. Not Provider Related

Third Digit (Outcome)

A. Failed criteria but within practice parameters
B. Clinical privileges limited
C. Clinical privileges suspended
D. Clinical privileges revoked
E. Remedical training stipulated
F. Proctor assigned
G-Z. Proctor assigned

Fourth Digit

Y - Entered into profile
N - Not entered into profile

AQCESS USERS MANUAL

TRIMIS Program Office
5401 Westbard Avenue
Bethesda, Maryland 20816

CONTRACT NO:
MDA 903-85-C-0107

23 SEPTEMBER 1985

NDC Federal Systems, Inc.
1300 Piccard Drive
Rockville, Maryland 20850

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SECTION 1. GENERAL

1.1 Purpose. The objective of the Users Manual for the Automated Quality of Care Evaluation Support System (AQCESS) is to provide the user's non-ADP personnel with the information necessary to effectively use the system.

1.2 Project References. The TRIMIS Program was formally created on July 11, 1974, by the Department of Defense Assistant Secretaries of Defense (Comptroller, and Health and Environment). The program is now managed and administered by the TRIMIS Program Office (TPO) of the Office of the Assistant Secretary of Defense (Health Affairs) [OASD(HA)]. Its purpose is to consolidate previous Service efforts and to "improve the effectiveness and economy of health care delivery in the Army, Navy, and Air Force." As this original tasking assignment stated, "TRIMIS will include development of automated information systems for timely patient-centered health data, supporting medical services, clinical research, epidemiological, and health care information."

The TPO has developed a microcomputer-based Clinical Records and Patient Administration (PAD) system using the MUMPS language and certain utilities from the Veterans Administration File Manager. The system has had extensive Tri-Service input. It is designed for efficient use by current patient administration personnel, and incorporates extensive service-specific edits of data to ensure reliable and accurate data collection. The system is designed to be easy to learn, provides on-line assistance to users, and can operate without dedicated computer operators and special environmental conditions. Being written in ANSI MUMPS, it can operate on a wide variety of hardware and is capable of modification to correct problems and to incorporate additional requirements. The Automated Quality of Care Evaluation Support System (AQCESS) was developed from the existing PAD software, and includes military department Clinical Records and Quality Assurance (QA) requirements.

The overall objectives of the AQCESS are to:

a. Improve the quality and timeliness of the evaluation of health care.

b. Provide administrative support for inpatient episodes.

c. Support the identification of variations which would adversely affect the quality of health care.

The following references relate to the history of the TRIMIS Program and the development of the AQCESS.

a. Data Base Specification for the Automated Quality of Care Evaluation Support System (AQCESS); NDC/FSI; April 11, 1985.

b. AQCESS System Specification: Patient Administration Subsystems; National Data Corporation/Federal Systems, Inc. (NDC/FSI); March 29, 1985.

c. AQCESS System Specification: Quality Assurance Subsystem; NDC/FSI; March 29, 1985.

d. Functional Description for an Automated Quality of Care Evaluation Support System (AQCESS); TRIMIS Program Office (TPO); January 25, 1985.

e. Acquisition of Devices to Develop, Implement and Maintain the Quality Assurance (QA) Support System for the Tri-Service Medical Information Systems Program Office; Defense Supply Service-Washington, Sol. No. MDA903-85-R-0101; October 12, 1984.

f. NAVMEDCOM 6320.8; Credentialing Program (Draft); September 1984.

g. NAVMEDCOM 6320.7; Quality Assurance Guide (Draft); September 1984.

h. AFR 205-16; Automatic Data Processing (ADP) Security Policy, Procedures, and Responsibilities; August 1, 1984.

i. AFR 168-13; Quality Assurance in the Air Force Medical Service; May 31, 1984.

j. MUMPS Patient Administration System Program Maintenance Manual (Draft); NDC/FSI; April 6, 1984.

k. MUMPS Patient Administration User Handbook (Draft); NDC/FSI; April 6, 1984.

l. Functional Description for CHCS Patient Administration (PAD) (Version 2.0); NDC/FSI; February 17, 1984.

m. Functional Description for Tri-Service Patient Administration System (Navy Version); Libra Technology; September 30, 1983.

n. AFR 168-4; Administration of Medical Activities; July 22, 1983.

o. Functional Description for Tri-Service Patient Administration System (Air Force Version); TPO; June 30, 1983.

p. Functional Description for Tri-Service Patient Administration System (Army Version); TPO; June 9, 1983.

q. DoD Standard 7935, Automated Data Systems (ADS) Documentation, February 15, 1983.

r. AR 40-66, (Change 2) Chapter 9; Medical Recorded Quality Assurance Administration; December 1, 1982.

s. AFR 125-37; The Resources Protection Program [PA; May 6, 1982 (and change 1)].

t. AFR 168-695; Medical Administrative Management System (Vols. I & II), July 18, 1980.

u. AR 380-380; Automated Systems Security; April 15, 1979.

v. AFR 300-13 (as amended); Safeguarding Personal Data in Automatic Data Processing Systems; March 14, 1976.

w. DoDD 5200.28-M; ADP Security Manual; January 1973.

x. DoDD 5200.28; Security Requirements for Automatic Data Processing (ADP) Systems; December 18, 1972.

1.3 Terms and Abbreviations.

A&D	Admissions and Dispositions
ACLS	Advanced Cardiac Life Support
ADP	Automatic Data Processing
ADT	Admission, Disposition, and Transfer
AMA	Against Medical Advice
AQCESS	Automated Quality of Care Evaluation Support System
ASMRO	Armed Services Medical Regulating Office
ATLS	Advanced Trauma Life Support
CHCS	Composite Health Care System
CPU	Central Processing Unit
CR	Clinical Records (Inpatient Records)
CRID	Clinical Records Identification (Inpatient Record Identification)
CRT	Cathode Ray Tube
CT	Coding Transcript
CTT	Coding Transcript Tape
DEERS	Defense Enrollment Eligibility Reporting System
DoD	Department of Defense
ER	Emergency Room
ES	Emergency Service
FD	Functional Description
FMP	Family Member Prefix
ICD	International Classification of Diseases
ICP	International Classification of Procedures
ID	Identification
IR	Inpatient Records (Clinical Records)
IRID	Inpatient Records Identification (Clinical Records Identification)
ITRCS	Inpatient Treatment Record Cover Sheet
JAG	Judge Advocate General
JCAH	Joint Committee for Accreditation of Hospitals
MEB	Medical Evaluation Board

MTF	Medical Treatment Facility
MTRC	Medical Treatment Recording Card
MUMPS	Massachusetts Utility Multi Programming System
NDC/FSI	National Data Corporation/Federal Systems, Inc.
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
PAD	Patient Administration
PTID	Patient Identification
QA	Quality Assurance
QAC	Quality Assurance Coordinator
QAP	Quality Assurance Program
QAS	Quality Assurance System (Navy Use Only)
R/ADT	Registration/Admission, Disposition, and Transfer (also referred to as A&D)
RIPT	Record of Inpatient Treatment
SSN	Social Security Number
TPO	TRIMIS Program Office
TRIMIS	Tri-Service Medical Information Systems
TRIPAD	Tri-Service Patient Administration System
UCA	Uniform Chart of Accounts
VSI/SI/SC	Very Seriously Ill/Seriously Ill/Special Category

1.4 Security. Because of the highly sensitve nature of the data collected and reported by AQCESS, security of this data is of utmost importance. Briefly, system security is ensured by the following measures: (1) use of system functions and access to data displays and reports are restricted to authorized users and designated terminals; (2) data is included on reports in the form of specific codes to protect confidentiality; and (3) the system includes a time-out feature, causing the screen display to disappear if a terminal is left unattended past a specified time limit.

SECTION 2. SYSTEM SUMMARY

2.1 System Application. The Automated Quality of Care Evaluation Support System (AQCESS) is an interactive, terminal-oriented, on-line computer system designed to manage patient administration, clinical, and quality of care information at MTFs. AQCESS is designed to provide a user friendly data collection system specifically sized for the Medical Treatment Facilities where installed. In addition to supporting patient administration, AQCESS will provide an invaluable tool for the quality assurance program in each MTF. The data collected during the patient's admission, disposition, and from review of the clinical records will be utilized to evaluate not only workload statistics by provider, ward, and UCA cost codes, but to allow review of inpatient episodes by diagnosis, procedure, outcomes, occurrences, and length of stay. This data will also be used, in conjuction with additional data input by the Quality Assurance Coordinator, to assist in reducing the intensive manual efforts in place at present. Additional benefits of the system will be greater accountability for inpatient days, improved bed management, more advanced record tracking, and a capability for ad hoc studies to support both management and clinical research.

2.2 System Operation. Development of the data base shall proceed basically as follows for all facilities:

a. As patients are registered and admitted, demographic data will be entered. Upon release from the hospital, further data will be entered by the dispositions clerk and clinical records office.

b. The data base will provide current listings of patients admitted and discharged, patients currently in the facility, and patients on convalescent leave, subsisting-elsewhere/out, or in the Medical Holding Company.

c. Following entry of procedure, diagnosis, and provider codes by the clinical records section, quality assurance reports will be generated both automatically and on an ad hoc basis.

d. Once a patient has been admitted, the data is available for use by the Quality Assurance Coordinator in developing information on that patient. Concurrent tracking of any positive occurrence from the Occurrence Screening Checklist will be possible.

e. After the patient is discharged, retrospective tracking of the patient will be performed to complete the occurrence screening checklist and perform any necessary audits.

f. The Quality Assurance Coordinator will also work with the risk manager for the MTF to track the reported incidents requiring follow-up.

g. Development of the automated provider credential file will also be the responsibility of the Quality Assurance Coordinator.

2.3 System Configuration. AQCESS runs on the PDP-11 series of computers manufactured by the Digital Equipment Corporation (DEC). There are three types of configurations:

a. PDP-11/23 (System 1). This is the smallest of the PDP-11 computers used by AQCESS. This hardware configuration consists of the PDP-11/23 processor with RD52 disk drive, the TK25 cassette tape drive, and the Letterwriter 100 console.

b. PDP-11/23 PLUS (System 2). This is the middle-sized computer used by AQCESS. This hardware configuration consists of the PDP-11/23 PLUS processor with RD51 and RD52 disk drives, the TK25 cassette tape drive, and the Letterwriter 100 console.

c. PDP-11/24 (System 3). This is the largest computer used by AQCESS. The hardware configuration consists of the PDP-11/24 processor, the RA80 disk drive, the TU80 mag tape drive, and the Letterwriter 100 console.

Both hard-copy and video display terminals are used to communicate with the PDP-11 computers. Hard-copy terminals print on continuous form paper, provide a permanent record of the terminal session, and are also used as the operating console. The hard-copy terminal for all three systems is the Letterwriter 100. Video display terminals print on a television-like screen called a cathode ray tube (CRT). The display terminal for AQCESS is the VT220. The Letterwriter 100 printer will be used to produce AQCESS reports and products.

2.4 System Organization. AQCESS consists of: the Access Control functions, the A&D subsystem (also referred to as R/ADT), the Clinical Records subsystem, and the Quality Assurance subsystem. The System Management function, usually considered part of the A&D subsystem, is described separately due to its importance to all components of AQCESS.

The patient administration subsystems, A&D and Clinical Records, collect registration data about military personnel, their eligible dependents, and other eligible beneficiaries admitted to the MTF. They also collect admission, disposition, and transfer data necessary to administer the MTF's inpatient population, and allow the correction of this data. In addition, patient administration processes enable the user to monitor bed availability figures, review statistics on specific segments of the inpatient population, and view data on previous hospital visits of individual patients. Through the Clinical Records subsystem, users are able to produce final clinical documentation on each inpatient episode.

Functions related to the management of the system are performed through the System Management function of AQCESS.

The Quality Assurance (QA) subsystem provides MTF command, professional, and administrative staff with automated support for the monitoring of quality of care within the MTFs. Information collected during patient registration, admission, disposition, transfer, and clinical records activities is used to facilitate identification, tracking, and documentation of quality assurance (QA) activities within the MTFs. The QA subsystem also contains specific functions for collecting, maintaining, and reporting QA data.

Each AQCESS subsystem consists of one or more functions or processes. Figure 2-1 lists the subsystems of the entire Automated Quality of Care Evaluation Support System, and the processes that make up each subsystem. The paragraphs to follow contain brief descriptions of these subsystems and their processes.

Access Control functions

- User Entry
- Patient Identification (PTID)

A&D (R/ADT) Subsystem

- Registration
- Admission
- Transfer
- Disposition
- Correction Management
- Bed Management
- Inpatient History
- Patient Inquiry
- R/ADT Reports

System Management function

Clinical Records Subsystem

- Clinical Records
- Clinical Records Reporting

Quality Assurance Subsystem

- Quality Assurance
- Profiling

Figure 2-1. AQCESS SUBSYSTEMS AND PROCESSES

2.4.1 Access Control Functions.

2.4.1.1 User Entry. User Entry protects the system and its data from unauthorized users and restricts users to those processes they are authorized to perform. Specifically, User Entry:

a. Receives and verifies the user ID and password.

b. Controls which processes can be performed at each terminal.

c. Allows a user access to authorized processes only.

2.4.1.2 Patient Identification (PTID). AQCESS uses six items of information to identify each patient: register number, patient name, family member prefix, date of birth, sponsor's Social Security Number, and sex. In PTID, users enter all of this data except register number to begin processing on new patients and to check their eligibility for care. Users can also conduct various searches to locate existing patient records by entering any of several combinations of the PTID data. Existing patient records must be located via the PTID process before those records can be processed in any of the patient-oriented functions (i.e., Registration, Admission, Disposition, Transfer, and Inpatient History).

2.4.2 A&D (R/ADT) Subsystem.

2.4.2.1 Registration. The user registers individuals as patients by entering demographic data on them and their sponsors via the Registration process. Specifically, Registration:

a. Collects, edits, and validates registration data, including:

   1. patient's race, marital status, address, religion, and military ID card expiration date.

   2. rank, branch of service, and flying status of patient or patient's sponsor.

   3. patient's military specialty and unit address.

b. Automatically retrieves patient address data if any other family member's record is on file.

c. Allows the user to update registration information.

d. Indicates whether registration data has been reviewed and verified as correct by the patient or patient's agent.

e. Is used to print Registration Forms, which contain registration data on the patient.

f. Displays data on the patient's most recent previous inpatient episode.

2.4.2.2 Admission. The user enters information about the inpatient episode via the Admission process in order to admit persons to the MTF as inpatients. Specifically, Admission:

a. Ensures that inpatients are registered before admission proceeds.

b. Collects, edits, and validates admission information, such as:

   1. date, time, and source of admission; admitting physician; and admitting diagnosis.

   2. length of service, if active duty.

   3. ward, physician, and clinical service assignments.

c. Collects, edits, and validates information on active-duty military who have Medical Evaluation Board (MEB) status, casualty status, or absent status.

d. Automatically generates a register number that identifies the patient's record if the MTF has chosen to have register numbers assigned by the system. (Through the System Management process, the MTF can choose to have register numbers assigned automatically or by the user; see section 2.4.3, below.)

e. Allows potential inpatients to be preadmitted.

f. Is used to produce Admission Forms and Index Cards, which contain admission information.

g. Allows users to admit newborns, by automatically retrieving applicable data from the mother's record, and forces the user to either disposition the newborn or change its status when the mother is put on convalescent leave.

h. Enables users to track patients who are the administrative responsibility of the MTF.

i. Allows users to cancel admissions or convert admissions to preadmissions.

j. Allows user to enter projected disposition data.

2.4.2.3 Transfer. The Transfer process enables the user to update administrative data when an inpatient's ward, clinical service, or physician assignment is changed. This process also allows users to update data on the patient's emergency contact, MEB status, casualty status, and absent status, to view other admission data, and to request printing of inpatient products.

2.4.2.4 Disposition. Through the Disposition process, the user enters data about the patient's discharge from the MTF and begins final processing of records on the inpatient episode. Specifically, Disposition:

a. Collects, edits, and validates disposition data, such as date and type of disposition and physician ordering the disposition.

b. Removes the patient from active ward and clinical service records, which are used in system reports.

c. Allows users to cancel dispositions.

d. Allows users to either disposition newborns at the time of the mother's disposition, or to track them as pay patients.

e. Allows users to view admission data and request inpatient products.

2.4.2.5 Correction Management. Correction Management is used to correct data that cannot be corrected through the other AQCESS processes. Through this process, users can:

a. Correct the following data as it appears on the patient record: patient category, length of service, source of admission, date and time of admission, date and time of disposition, disposition type, absent statuses, clinical services, and inter-ward transfers.

b. Add appropriate absent status, clinical service, and inter-ward transfer data omitted from a patient's record during admission.

c. Add remarks to the Admission and Disposition (A&D) Report (1) to alert others that erroneous data was included on previous A&D Reports and (2) to explain changes or additions described in (a) and (b).

2.4.2.6 Bed Management. This process maintains statistics on the numbers of beds that are occupied or available on each ward and enables users to monitor ward statuses in the MTF. Specifically, Bed Management:

a. Adjusts and computes bed availability figures for each ward.

b. Allows users to create new Ward Status records and to delete existing Ward Status records (except when the ward to be deleted has any occupied or reserved beds).

c. Displays total figures on bed availability for the entire MTF.

d. Allows users to adjust the number of total beds and blocked beds on a ward.

2.4.2.7 Inpatient History. Through this process, users can review information about inpatient episodes of active and dispositioned patients. Inpatient History keeps track of all inpatient episodes for an individual patient. It can display a list of episodes for a patient who has been admitted more than once, and allow users to choose an episode for review. Specifically, Inpatient History displays the following data on individual episodes:

a. Register numbers, admission dates, disposition dates, and admission diagnosis codes on patients with more than one inpatient episode.

b. PTID data, patient category, rank, branch of service, religion, source of admission, and admission date and time.

c. Disposition type, disposition date and time, clinical service, ward, type case, archive date, primary discharge diagnosis and principal procedure performed.

2.4.2.8 Patient Inquiry. This process identifies segments of the patient population according to categories specified by the MTF, and lists patients who fall into those categories. The MTF may specify categories such as ward, physician, diagnosis, etc. For example, through Patient Inquiry the user may view a list of all inpatients currently on a given ward.

2.4.2.9 R/ADT Reports. Through this function, users enter requests to print the reports listed below. These reports, which are generated from data entered via the A&D subsystem processes, are described in detail in Part 2 of Appendix A.

a. Admission and Disposition Report.

b. Admission and Disposition Recapitulation or Patient Strength Report.

c. Admission Notification Letters.

d. Admission Summary by Name or Register Number.

e. Alpha Roster of Hospital Inpatients.

f. Command Interest Report.

g. Daily Admissions by Diagnosis.

h. Death Report

i. Disposition Notification Letters.

j. Disposition Summary by Name or Register Number.

k. Injury Report.

l. Long-Term Patient Roster.

m. Patient Charge Roster.

n. Preadmission List.

o. Projected Dispositions by AFSC/MOS.

p. Register of Patients.

q. Roster of VSI/SI/SC Patients.

r. Status Out Roster.

s. UCA Disposition Report.

t. UCA Inpatient Occupied Bed Days Report.

u. Ward Nursing Report.

2.4.3 System Management Function. The System Management function is used by the System Manager to maintain data that regulates the operation of AQCESS. Specifically, this process allows the System Manager to:

a. Maintain the list of all system tables, which can be displayed on a screen, and select tables to be printed in hard-copy form.

b. Maintain and update the system tables.

c. Maintain profile data that identifies the MTF, including its military department, and profile data that regulates certain system functions, such as dates for archiving files. The System Manager also uses this process to indicate whether register numbers will be assigned automatically or manually, and to reserve or release blocks of register numbers for manual or automatic assignment to records.

d. Regulate system security by user ID and terminal ID, and to designate system capabilities authorized to individual users and terminals.

e. Produce the Invalid Sign-On Log and the List of Current Passwords.

2.4.4 Clinical Records Subsystem.

2.4.4.1 Clinical Records. Through Clinical Records, users perform the final processing on each inpatient episode and produce documentation on dispositioned patients for the patient chart as well as for reporting to higher commands. Specifically, Clinical Records:

a. Collects, edits, and validates data on each diagnosis made and each procedure (i.e., operation) performed during the hospital visit.

b. Collects and maintains data on previous inpatient episodes at other hospitals from which the patient transferred to this MTF.

c. Computes and maintains data on the number of days a patient spent in various clinical services and absent statuses during this inpatient episode.

d. Allows the user to enter administrative data; displays and collects codes for non-procedural physicians associated with this episode.

e. Tracks items missing from the record and posts them as delinquencies on the Provider Profile after a period of time (which is specified by the MTF).

f. Initiates final edits on the record and generates the Inpatient Treatment Record Cover Sheet (ITRCS) or Record of Inpatient Treatment (RIPT) and the Coded Episode Summary (CES).

g. Produces reports (printouts, report format tapes) including the coding transcript.

2.4.4.2 Clinical Records Reports. Through this process, users initiate end-of-month processing on records and enter requests to print the following reports, which are described in detail in Part 2 of Appendix C.

a. Clinical Records Returned to A&D.

b. End-of-Month Summary (Navy only).

c. Roster of Delinquent Records.

d. Incomplete Inpatient Medical Records Report.

2.4.5 Quality Assurance Subsystem.

2.4.5.1 Quality Assurance. The QA function enables the MTF to monitor quality of care indicators, and allows for the identification, documentation, and tracking of quality of care problems occurring at the MTF. Through this function, users are able to:

a. Identify problems by initiating audits of clinical documentation based on multiple criteria developed at the MTF level. The criteria include such factors as length of stay at unit and MTF, diagnosis, specific procedures, treatment, morbidity, and others.

b. Document problems, solutions, recommendations, re-evaluation dates, and follow-up activities. Documentation includes such information as the type of problem, the source of information, type of person involved (patient, visitor, etc.), and other factors.

c. Track problems, solutions, follow-up actions, and other QA Committee activities, and produce reports or displays of requested data.

The system will provide, at a later date, a means of identifying patient care trends according to specified criteria using ad hoc reporting.

Specifically, the QA function:

a. Provides data to assist in the Occurrence Screening program both for inpatients and for Emergency Service patients (through the Occurrence Screening subfunctions).

b. Allows input of significant incidents and recall of these incidents sorted to highlight various areas of high risk (through the Incident Reporting subfunction).

c. Enables identification and tracking of QA problems by activity and status (through the Problem Audit Tracking subfunction).

d. Generates the following reports on quality assurance activities (through the Reports subfunction):

1. Blood Utilization Pull List.

2. Delinquent Occurrence Screening List.

3. Incident Summary.

4. Diagnosis Index by Provider.

5. Dispositions by Diagnosis Report.

6. Occurrence Screening Pull List - Emergency Service.

7. Occurrence Screening Pull List - Inpatient.

8. Occurrence Screening Summary, Facility - Emergency Service.

9. Occurrence Screening Summary, Facility - Inpatient.

10. Occurrence Screening Summary, Provider - Emergency Service.

11. Occurrence Screening Summary, Provider - Inpatient.

12. Occurrence Screening Summary, Specialty.

13. Occurrence Screening Suspense List - Emergency Service.

14. Occurrence Screening Suspense List - Inpatient.

15. Provider Occurrence Screening Audit - Emergency Service.

16. Provider Occurrence Screening Audit - Inpatient.

17. Quality Assurance Problem Audit.

18. Surgical Index by Provider.

19. Surgical Operations Report.

These reports are described in detail in Part 2 of Appendix D.

2.4.4.2 Profiling. The Profiling function maintains the administrative data and clinical indicators for inclusion on the Provider Profile. This function is accessible only by personnel designated by the MTF Commander--normally the Credentials Committee Chairman and the Credentials Committee Secretariat. Authorized users are able to query the system for a Credentials Pull List, which lists providers by specialty and gives the dates of their last credentials reviews. The Credentials Committee uses the Provider Profile and the Provider Procedure/Mortality Summary when formulating its recommendations to the Commander regarding the privileges to be granted to providers. This function generates the following reports:

a. Credential Pull List.

b. Provider Procedure/Mortality Summary.

c. Provider Procedure Summary.

d. Provider Profile.

e. Providers with Insufficient Continuing Education.

These reports are described in Part 2 of Appendix D.

2.5 Performance. AQCESS will provide automated data collection, storage, sorting, analysis, and reporting for military inpatient facilities. Data input will be through entry at CRT terminals in the Admissions and Dispositions (A&D) areas, in the Clinical Records office, and in the Quality Assurance Coordinator's area. The input will be real-time while the patient or record is present; this will eliminate the need to create a paper record and then enter the data into the system. This real-time processing will result in the shortening of patient, record, and staff processing time. The System Manager will assign user IDs, passwords, and user privileges, precluding unauthorized use of terminals or printers.

Following information processing, several automated outputs will be generated daily and monthly. These outputs are listed in Figure 2-2, and will be produced at designated printers based on the requirements of the military department and the inpatient facility. Additionally, reports will be available on an "as needed" basis. Reports will be generated during low-use times to prevent interference with A&D processing, which would delay reports and slow patient processing.

Once created, records from the Clinical Records section will be screened for a great variety of errors. The Clinical Records subsystem will not allow completion of any case until all errors are corrected. Errors discovered through Clinical Records can be corrected through Correction Management or another A&D function.

Projected interfaces with DEERS and CASH are but two of the future functions foreseen. Utilization of AQCESS in related areas within the facility will require study and approval by the TRIMIS Program Office.

2.6 Data Base. See Appendix G to this document, File Descriptions.

A&D (R/ADT) Reports

Admission and Disposition Report
Admission and Disposition Recapitulation/
  Patient Strength Report
Admission Notification Letters
Admission Summary by Name or Register Number
Alpha Roster of Hospital Patients
Command Interest Report
Daily Admissions by Diagnosis
Death Report
Disposition Notification Letters
Disposition Summary by Name or Register Number
Injury Report
Long-Term Patient Roster
Patient Charge Roster
Preadmission List
Projected Dispositions by AFSC/MOS
Register of Patients
Roster of VSI/SI/SC Patients
Status Out Roster
UCA Disposition Report
UCA Inpatient Occupied Bed Days Report
Ward Nursing Report

R/ADT Products

Registration Form
Admission Form
Index Card

System Management Reports

Invalid Sign-On Log
List of Current Passwords

Clinical Records Reports

Clinical Records Released to A&D
End-of-Month Summary (Navy only)
Incomplete Inpatient Medical Records Report
Roster of Delinquent Records

Clinical Records Products

Coded Transcript Tape
Coded Episode Summary
ITRCS/RIPT
Error List

Figure 2-2. AQCESS OUTPUTS, BY SUBSYSTEM (page 1 of 2)

QA Reports

Blood Utilization Pull List
Credential Pull List
Delinquent Occurrence Screening List
Diagnosis Index by Provider
Dispositions by Diagnosis Report
Incident Summary
Occurrence Screening Pull List,
  Emergency Service and Inpatient
Occurrence Screening Summary:
  Facility, Emergency Service & Inpatient
  Provider, Emergency Service & Inpatient
  Specialty (Inpatient)
Occurrence Screening Suspense List,
  Emergency Service and Inpatient
Provider Occurrence Screening
  Audit, Emergency Service and
  Inpatient
Provider Procedure/Mortality
  Summary
Provider Procedure Summary
Provider Profile
Providers with Insufficient
  Continuing Education Report
Quality Assurance Problem Audit
Surgical Index by Provider
Surgical Operations Report

Figure 2-2. AQCESS OUTPUTS, BY SUBSYSTEM (page 2 of 2)

2.7 General Description of Inputs, Processing, Outputs.

a. Inputs

1. Purpose of Input - Data is entered to provide a data base for comparison with established criteria and standards of care. Data will be entered as required upon admission or discharge of patients, as needed by the Quality Assurance Coordinator and the risk manager, and as records are processed for diagnosis, procedure, and provider analysis.

2. Content of Input - User input does not contain operational, control, or reference data. AQCESS data consists of demographic data about patients; data about inpatient admissions, dispositions, and transfers within the hospital; bed availability statistics; diagnoses and procedures; occurrence screening checklist responses; physician profile data; and data related to problems or incidents at the MTF.

3. Associated Inputs - AQCESS requires direct input only.

4. Origin of Inputs - Data will be derived through interview of the patient, sponsor, or parent, and review of the clinical record. Data for quality assurance will be derived through input from Occurrence Screening Checklists, Incident Reports, and credentials file information, as well as from inputs to the

patient administration and Clinical Records components of AQCESS.

5. Data Files - For a chart identifying the source of input (in boldface) and the associated data files that are built from that input, see Figure 2-3.

6. Security Considerations - Due to the confidentiality of the data being collected, security will be of utmost importance. Use of system functions will be strictly limited by office and function, as well as password. Data input into the system will be displayed on AQCESS screens; these screens will time out if no data or commands are entered by a user within a specified length of time. Space security will be an additional consideration.

b. Processing. The general flow of data through the system is illustrated by Figure 2-4. This data flow proceeds as follows: Demographic data on individual patients is entered through PTID and the Registration function. Data on the patient's admission is entered through Admission. Data on changes to the patient's ward, clinical service, and absent statuses can be entered either through Admission or Transfer. Data on the patient's discharge is entered through the Disposition function. Through Correction Management, specific data on the inpatient episode can be corrected. Diagnosis, procedure, provider, and record tracking data are entered through the Clinical Records function, where final processing on the records of dispositioned patients is carried out. When records are complete and error-free, they are approved via Clinical Records, and information on these records is sent to higher commands.

Responses to occurrence screening checklist questions are entered through the Quality Assurance function. The inpatient occurrence screening checklist for a given patient is not complete until that patient's record has been approved in Clinical Records and AQCESS has compared the checklist to the approved record. Clinical Records data can cause certain occurrence screening questions to default to "yes." Results of QA reviews of affirmative responses are entered in Quality Assurance; if reviews validate these occurrences, the validated occurrences are automatically posted to the appropriate provider profile(s).

In addition to validated occurrences, provider profiles contain data on physician certification, licensing, and continuing education. The number of procedures the physician performs, the total discharges, the total deaths, and medical record delinquencies are posted automatically from data obtained from Clinical Records. Other profile data is entered through the Profiling function.

This is a summary of the general flow of information through the system. AQCESS also enables users to automatically produce numerous reports from the

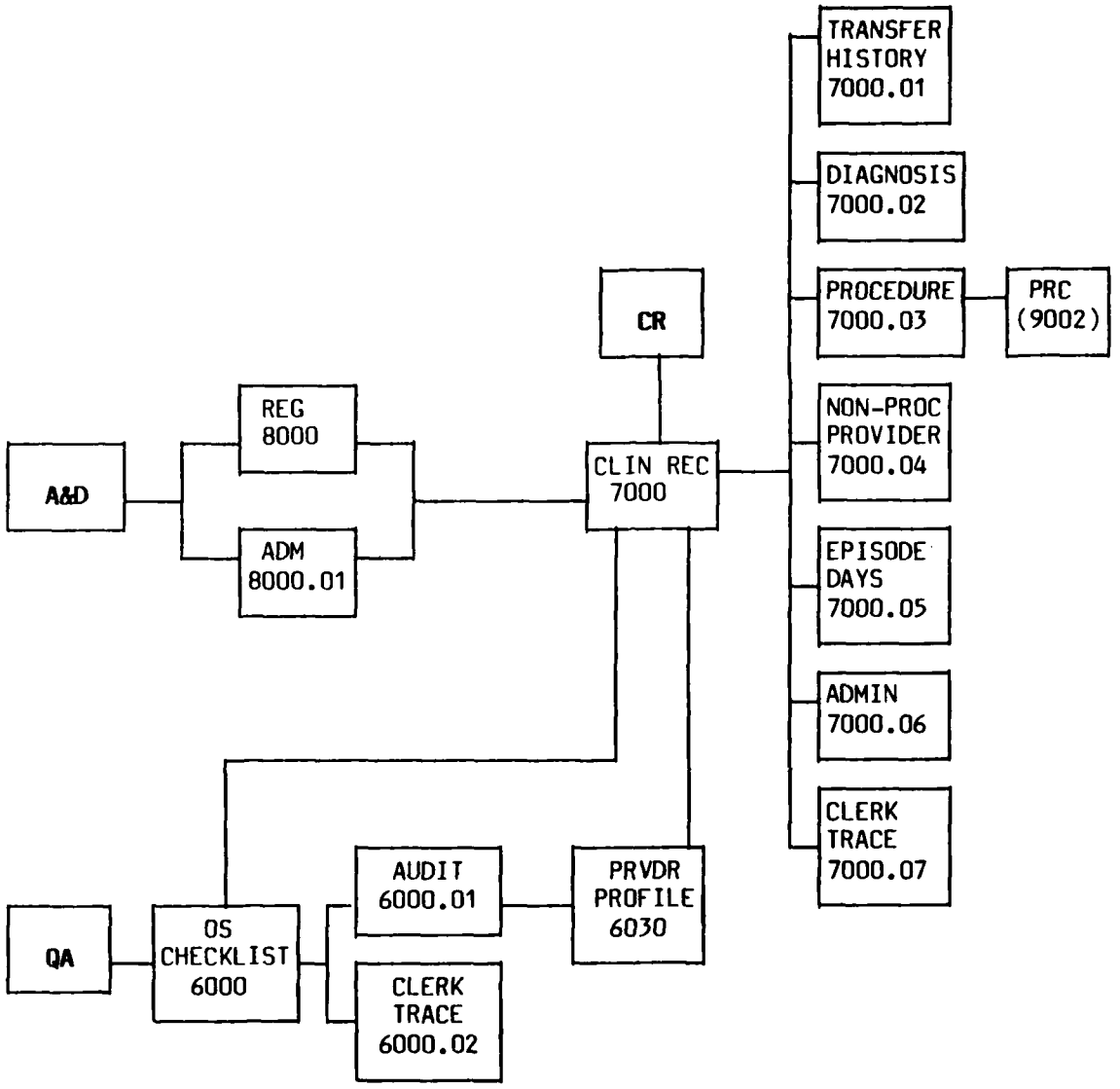

Figure 2-3. RELATIONSHIP OF INPUTS TO DATA FILES CREATED

data entered, to track Emergency Service occurrences, incidents, and problems, to keep bed availability statistics, and to perform information desk functions. Through the System Management function, the system manager (1) manages system operations, (2) regulates system functions such as register number assignment and authorization of user privileges, and (3) maintains the system tables.

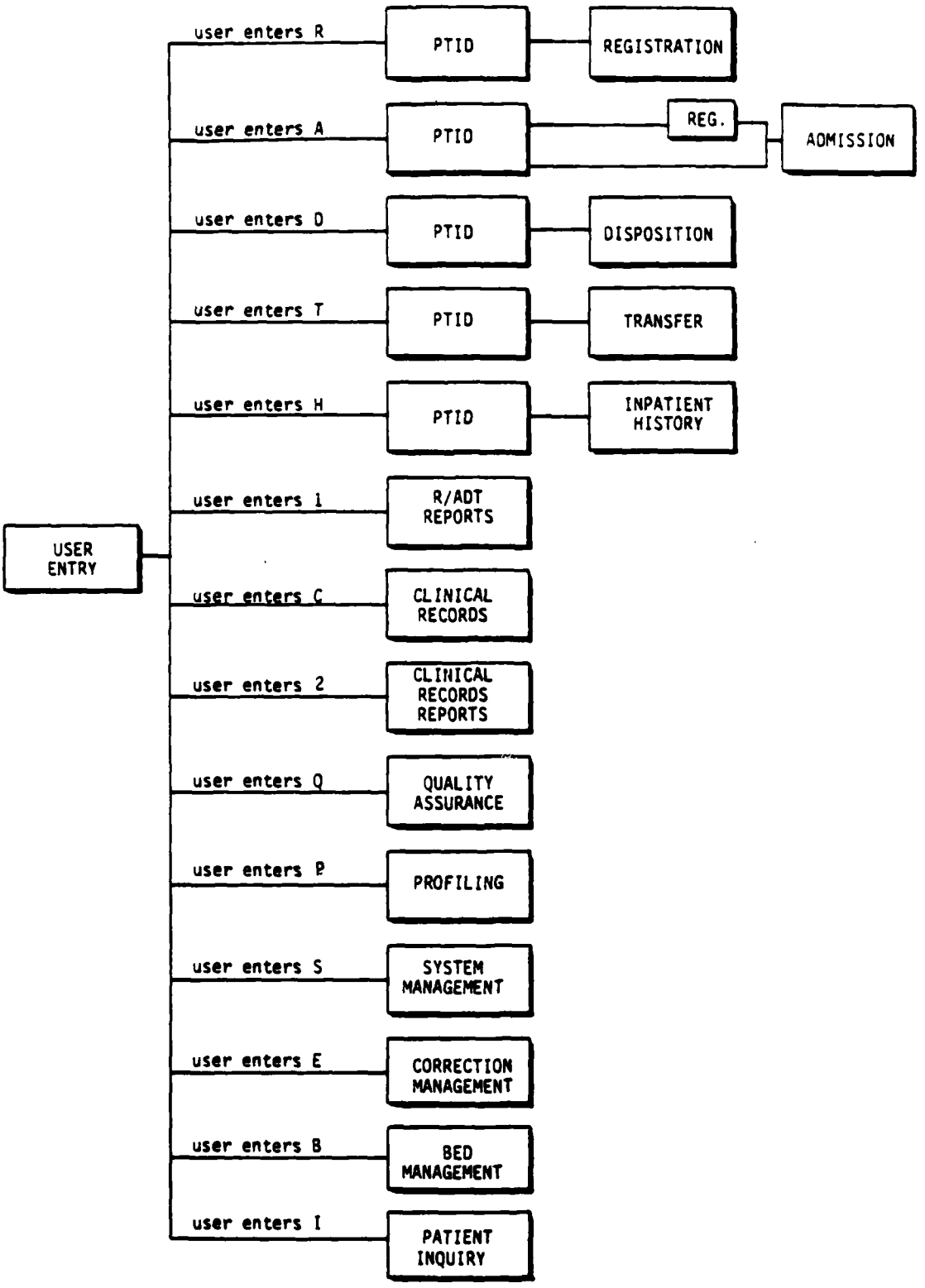

Figure 2-4. AQCESS LOGICAL FLOW

c. Outputs. For general descriptions of the AQCESS outputs, see the sections below. Outputs are grouped according to the three subsystems and the System Management function. Further information on these outputs is contained in the Appendixes to this document (Part 2 of each of the following: Appendix A, A&D subsystem; Appendix B, System Management; Appendix C, Clinical Records subsystem; and Appendix D, Quality Assurance subsystem). These appendixes give information about each output's purpose, contents, format, relationship to inputs, production, distribution, and any associated outputs. They also include examples of each output.

Security considerations in relation to outputs are the same as described in paragraph 2.7.a.6 above. Outputs can only be requested by authorized users and will only print in designated locations. On QA reports, health care providers are indicated by special codes to protect confidentiality of data.

In addition to the outputs listed, AQCESS will provide an ad hoc reporting capability by which users can produce a variety of outputs tailored to the MTF's needs.

2.7.1 A&D (R/ADT) Outputs. Data input through the A&D subsystem yields the outputs described below. All of the reports described in this section are associated with and complement each other. Except where otherwise indicated, each report is requested by the user through the R/ADT Reports function.

a. Admission and Disposition Report - describes all admissions, dispositions, changes of absent status, and newborn activity, as well as corrections to this data. Produced daily, usually at midnight; a partial report can be run on demand.

b. Admission and Disposition Recap/Patient Strength Report - summarizes A&D data by patient category and absent status, and for newborns.

c. Admission Cover Sheet or Admission Form - contains patient identification and admission information on an individual patient. Requested by the user from the Admission or Transfer function.

d. Admission Notification Letters - notify unit commanders of active-duty personnel in their commands whose inpatient admissions were entered in AQCESS on the report date.

e. Admission Summary by Name or Register Number - summarizes all admissions effective in the report month, sorted by patient name or register number.

f. Alpha Roster of Hospital Inpatients - lists all current inpatients, in alphabetical order, showing current ward, clinical service, and absent status, and giving demographic information about each patient. Distributed to A&D Desk to be used as a reference.

g. Command Interest Report - lists all patients by command interest status.

h. Daily Admissions by Diagnosis - gives information about admissions for a given day for each diagnosis, giving demographic data on each admission.

i. Death Report - lists all deaths occurring during the report period, sorted by disposition date and, within date, by name.

j. Disposition Notification Letters (Army only) - notify unit commanders of active-duty enlisted personnel in their commands whose dispositions were entered in AQCESS on the report date.

k. Disposition Summary by Name or Register Number - summarizes all dispositions effective in the report month, sorted by patient name or register number.

l. Index Card (3x5 Card or 5x8 Card) - contains admission data, and is requested by the user from the Admission or Transfer function.

m. Injury Report - lists each patient whose type case indicates injury. and gives demographic data on the patient.

n. Long-Term Patient Roster - lists current inpatients who have been under hospital care for more than the number of days specified at run time; sorted by patient name and, within name, by register number.

o. Patient Charge Roster (Army only) - lists current charges for all inpatients or patients dispositioned on the run date; sorted by patient name.

p. Patient Strength Report - see A&D Recap.

q. Preadmission List - gives data on each current preadmission.

r. Project Dispositions by AFSC/MOS - lists all patients for whom projected dispositions have been entered, sorted by military specialty.

s. Register of Patients - lists the register numbers assigned, with summary patient data, for each day of the report period (can be used in place of DD739).

t. Registration Form - contains registration data on an individual patient. Requested by the user from the Registration function.

u. Roster of VSI/SI/SC Patients - lists, by ward and clinical service, all patients whose casualty code is Very Seriously Ill, Seriously Ill, Special Category, or Terminally Ill. Includes demographic data, diagnosis, and prognosis for each patient.

v. Status Out Roster - lists patients currently out of the hospital, giving their current absent status and expected return date, and indicating whether return is overdue.

w. UCA Disposition Report - gives the number of patients that have been dispositioned during a given month, by UCA Clinical Service code. Produced monthly.

x. UCA Inpatient Occupied Bed Days Report - shows the number of bed days accumulated for each clinical service and ward for a given month. Also shows total bed days per clinical service, total bed days per ward, and a grand total of all bed days for the month. Produced monthly.

y. Ward Nursing Report - alphabetically lists all inpatients currently assigned to each ward, by ward. Gives demographic and admission data on each patient, and includes bed availability data for each ward. Produced daily, usually at midnight.

2.7.2 System Management Outputs. The System Management reports are produced from data entered in System Management or regulated by it. These reports are requested by authorized users from the System Management function (the User ID/Terminal Maintenance Menu).

a. Invalid Sign-On Log - gives information about any incorrect entry of user IDs and passwords. Produced on request of the System Manager, who also specifies the time period of this report.

b. List of Current Passwords - lists the current user IDs and passwords, including the date when these passwords were last changed, and the privileges allowed to each ID-password combination. Produced on request of the System Manager.

2.7.3 Clinical Records Outputs. The outputs described in this section are produced from data retrieved from A&D functions, edited by the Clinical Records subsystem, and supplemented by data entered via the Clinical Records subsystem or calculated by it. The means of requesting each output is specified below.

a. Clinical Records Returned to A&D - lists records that have been returned to A&D for correction. Includes patient identification data, date of disposition, and the reason for the release to A&D. Requested by the user from the Clinical Records Report function.

b. Coded Episode Summary - lists the data included on the Coded Transcript Tape in hard-copy form; contents differ for each military department, as per regulations. Requested by the user from the Clinical Records function.

c. Coded Transcript Tape(s) - a machine-readable report on records that have been processed in the Clinical Records subsystem and approved for inclusion on this tape by the Clinical Records supervisor. Includes final records on patients. The Coded Transcript Tape contains data specified by regulations for each military department. It is requested by the System Manager at the operations console.

d. End-of-Month Summary (Navy use only) - gives summary statistics for all inpatient episodes that are included on the report to higher commands--specifically, on all admissions and dispositions for the month, giving figures for those that have been completely processed in CR and those that are incomplete. Requested by the user from the Clinical Records Report function.

e. Error List - lists any errors in the record that were discovered by Clinical Records edits. Produced automatically after the Coded Episode Summary or the ITRCS/RIPT.

f. Incomplete Inpatient Medical Records Report - lists incomplete records of patients, by the provider responsible for the missing item(s).

g. Inpatient Treatment Record Cover Sheet or Record of Inpatient Treatment (ITRCS/RIPT) - contains data on an individual inpatient episode that has been accessed in Clinical Records. Requested by the user from the Clerk Actions Screen.

h. Roster of Delinquent Records - lists records that have not been completely processed in Clinical Records within the time limit set by the MTF, and which are therefore delinquent. Requested by the user from the Clinical Records Report function.

2.7.4 Quality Assurance Outputs. These outputs are produced from data retrieved from the Clinical Records subsystem and data entered through the Quality Assurance subsystem. The Quality Assurance subsystem consists of the Quality Assurance function and the Profiling function. For ease of discussion, the QA reports are grouped by these functions.

2.7.4.1 Quality Assurance Reports.

a. Blood Utilization Pull List - summarizes blood product utilization, by care provider, over a specified period of time; lists records that are to be reviewed by the Blood Utilization Review Committee.

b. Delinquent Occurrence Screening List - lists all patients whose inpatient occurrence screening checklist is not completed within the period of time after disposition specified by the MTF.

c. Diagnosis Index by Provider - gives information on diagnoses entered in Clinical Records, by provider of care.

d. Dispositions by Diagnosis Report - gives information on diagnoses of patients discharged during the reporting period.

e. Incident Summary - summarizes incidents occurring at the MTF during a specified time period.

f. Occurrence Screening Pull List, Inpatient and Emergency Service - these two reports identify patient records involved in occurrence screening discrepancies, allowing these records to be pulled for review.

g. Occurrence Screening Summaries. These reports summarize occurrence screening data. The inpatient summaries listed below (Facility, Provider, and Specialty) come in two versions. (1) Users can request inpatient summaries containing raw data, which is information on all affirmative responses to checklist items, whether validated or not. Raw data is reported by the primary or responsible provider. Or (2) users can request inpatient summaries containing information only on validated variations; validated data is reported by the provider that the validated variation was posted to.

   1. Facility Occurrence Screening Summary, Inpatient and Emergency Service - summarize affirmative checklist responses for the two checklists. The inpatient summary groups checklist data by the specialty of the patient's physician (if the provider has more than one specialty, the report will show the specialty that relates to this case). The emergency service summary groups data by provider.

   2. Provider Occurrence Screening Summary, Inpatient and Emergency Service - summarize affirmative checklist responses for an individual provider, for a specified period.

   3. Specialty Occurrence Screening Summary - summarizes, for affirmative checklist responses for a specified time period, by clinical specialty of the provider. If the provider has more than one specialty, the report will show each specialty and the cases assigned to the doctor in relation to that specialty.

h. Occurrence Screening Suspense List, Inpatient and Emergency Service - these two reports list occurrence screening open items that have been assigned for review and have not been returned.

i. Provider Occurrence Screening Audit, Inpatient and Emergency Service - these two reports list, by provider, all QA actions taken on exceptions to occurrence screening standards.

j. Quality Assurance Problem Audit - presents data about QA problems, either resolved or unresolved.

k. Surgical Index by Provider - gives information on surgical procedures performed during the reporting period.

l. Surgical Operations Report - gives information on surgical procedures performed during the MTF during the reporting period.

2.7.4.2 Profiling Reports.

a. Credential Pull List - lists providers by specialty, to facilitate pulling the provider's credential file and performing credential review.

b. Provider Procedure/Mortality Summary - presents the mortality rate for procedures that fall within any of the 26 categories of procedures that are reportable to DoD. It gives one page of mortality statistics for each provider recorded as the primary provider, secondary provider, or teaching assistant involved in performing a procedure that was associated with a patient's death.

c. Provider Procedure Summary - gives mortality information for all procedures performed at the MTF that were associated with a patient death, by providers recorded as primary or secondary provider or teaching assistant.

d. Provider Profile - for individual providers, gives dates for credentials and license renewals, continuing education and certification data. Also shows the following data, where applicable, accumulated for six-month periods: number of procedures performed, patients discharged, malpractice claims filed, medical records deficiencies and delinquencies, and validated complaints, validated variations related to antibiotic use, normal surgical tissue, and transfusions, validated variations detected through occurrence screening, and total deaths.

e. Providers with Insufficient Continuing Education - lists providers who have fewer credit hours of continuing education than the number entered by the user requesting the report.

SECTION 3. STAFF FUNCTIONS RELATED TO TECHNICAL OPERATIONS

3.1 Initiation Procedures. For an explanation of how to log on to the AQCESS system, see Section 3 of the AQCESS System Specification: PAD Subsystems, "User Entry."

3.2 Staff Input Requirements. The information called for in this section is not applicable to AQCESS, since it is an on-line rather than a batch system.

3.2.1 Input Formats. All AQCESS data entry occurs via screens displayed on a CRT terminal. An example of each AQCESS screen is contained in the Appendixes to this document (Part 1 of each of the following: Appendix A, A&D (R/ADT) subsystem; Appendix B, System Management function; Appendix C, Clinical Records subsystem; and Appendix D, Quality Assurance subsystem).

3.2.2 Composition Rules. For the rules and conventions regarding what input will be accepted by AQCESS, see Part 1 of Appendixes A, B, C, and D.

3.2.3 Input Vocabulary. For a listing of valid codes used to input data into the system, see Appendix F, Tables.

3.2.4 Sample Inputs. All input into the AQCESS system can be classified as alphabetic, numeric, alphanumeric, or free text. See Part 1 of Appendixes A, B, C, and D for inputs through screens. Classifications such as header, text, trailer, omissions, and repeats do not apply to AQCESS inputs.

3.3 Output Requirements.

a. Purpose - see Sections 2.7.c, and 2.7.1 through 2.7.4 of this document, General Description of Inputs, Processing, and Outputs.

b. Time - see Part 2 of Appendixes A, B, C, and D.

c. Options - see Section 4.3, Query Preparation.

d. Media - see Part 2 of Appendixes A, B, C, and D.

e. Location - The location where the output is required to appear will be determined by the individual MTFs.

f. Other - see Part 2 of Appendixes A, B, C, and D.

3.3.1 Output Formats. For descriptions of the header and trailer data, and the format of the body of each AQCESS output, see Part 2 of Appendixes A, B, C, and D.

3.3.1.1 Ad Hoc Reporting Capability. Ad hoc reporting capability is to be developed under Phase II of the AQCESS contract. A description of it will be submitted at a later date.

3.3.2 Sample Outputs. Examples of each output produced by AQCESS are included in Part 2 of Appendixes A, B, C, and D.

a. Definition - see Part 2 of Appendixes A, B, C, and D.

b. Source - see Part 2 of Appendixes A, B, C, and D.

c. Characteristics - not applicable to on-line systems.

3.3.3 Output Vocabulary. Part 2 of Appendixes A, B, C, and D describe the codes used in AQCESS reports, and refer to the system tables containing codes, where appropriate.

3.4 Utilization of System Outputs. The use of each AQCESS output is described in Part 2 of Appendixes A, B, C, and D.

3.5 Recovery and Error Correction Procedures. For a list of the error codes that the system can display, see Appendix H, Error Codes. Procedures to be followed in correcting the errors represented by these codes vary with each error and with the particular circumstances surrounding the error. In case of an abnormal termination of a user's job due to software errors, the system automatically records the information necessary for restart and recovery. The System Manager requests a printout of this information (the Error Log) and forwards the information to NDC/FSI. NDC personnel determine the problem and relay the procedures necessary to correct it.

SECTION 4. FILE QUERY PROCEDURES

4.1 System Query Capabilities. An ad hoc reporting capability will be developed under Phase II of the AQCESS contract; a description of this capability will be submitted at a later date.

4.2 Data Base Format. Figure 5-1 illustrates the format of the data base used by this system. See also Appendix G of this document, File Descriptions, and the AQCESS Data Base Specification, reference 1.2.e.

4.3 Query Preparation. Not available at this time (see 4.1, above).

4.4 Control Instructions. The information called for in this section is not applicable to AQCESS, since it is an on-line rather than a batch system.

SECTION 5. TERMINAL DATA DISPLAY AND RETRIEVAL PROCEDURES

5.1 Available Capabilities. AQCESS data is displayed through a series of screens associated with each selection on a main menu. Data aggregated in the form of reports can be viewed at terminals and can be printed out on paper.

5.2 Data Base Content. The content of the data base is patient administration and clinical records data, responses to Inpatient and Emergency Services Screening Checklists, incident and problem reporting data, and provider profile data. All of this data is available for terminal display and retrieval. Figure 5-1 illustrates the format of the data base used by the system.

5.3 Access Procedures. AQCESS and its data base are accessed through a Sign-On Screen, on which the user enters a user ID and password. Associated with each valid user ID and password are the system capabilities that the user is authorized to perform. When the system determines that the user ID and password are valid, a main menu, the User Entry Menu Screen, is displayed indicating the functions authorized to the user, and the functions that can be performed at the particular terminal.

Through the System Management function the System Manager specifies the particular functions authorized to each user and terminal. For security reasons, certain functions are restricted to only one or a few users. The System Management function can only be accessed by the System Manager and is usually only available to that one user. Quality Assurance and Profiling functions can only be performed by the Quality Assurance Coordinator.

AQCESS system functions are as follows:

Registration Processing
Admission Processing
Disposition Processing
Transfer Processing
R/ADT Reports
Inpatient History
Patient Inquiry
Clinical Records Processing
Clinical Records Reports
Bed Management Processing
Correction Management
System Management
Quality Assurance
Profiling

These functions comprise the subsystems that make up AQCESS. The breakdown of functions by subsystem is shown in Figure 5-2.

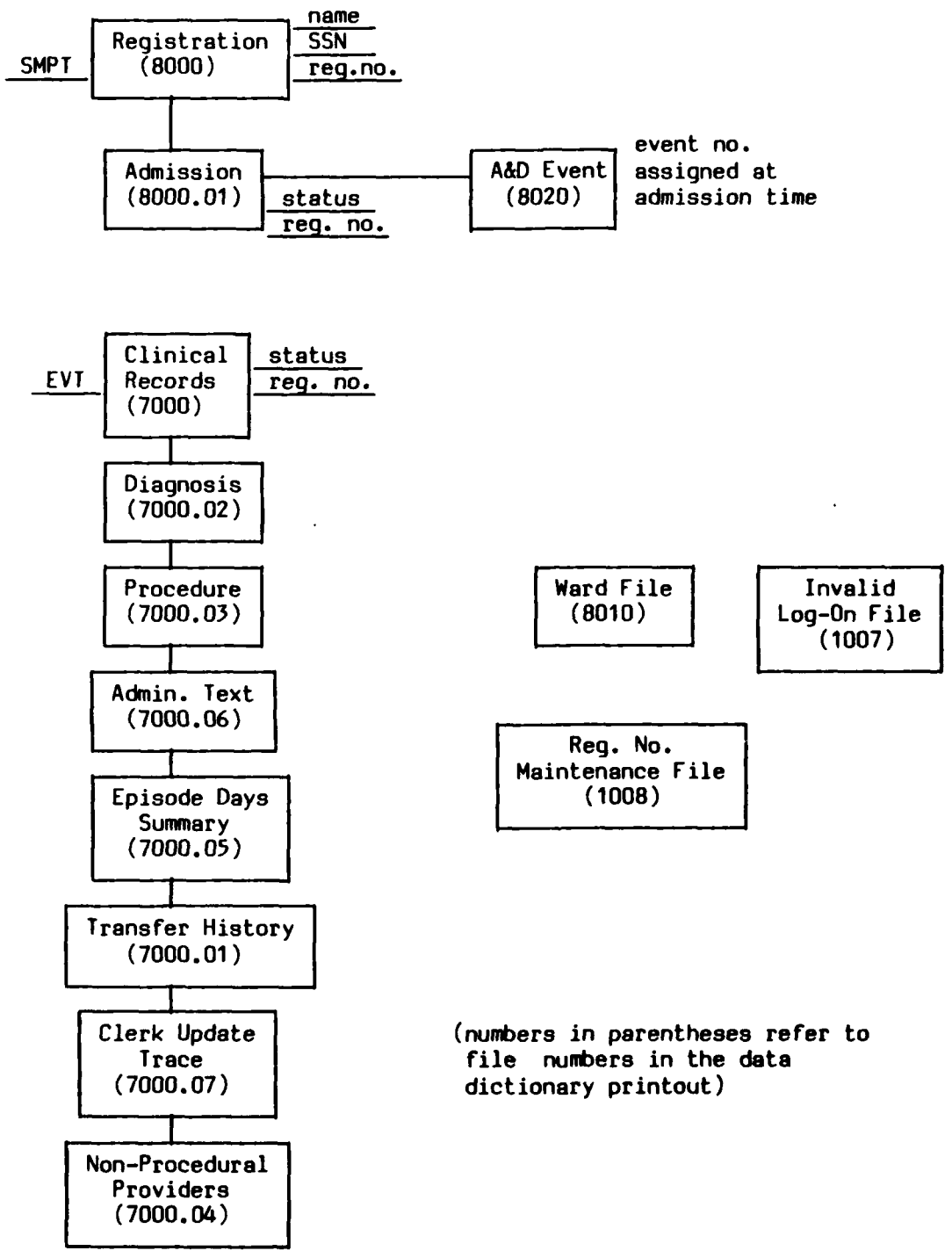

Figure 5-1. DATA BASE FORMAT (page 1 of 2)

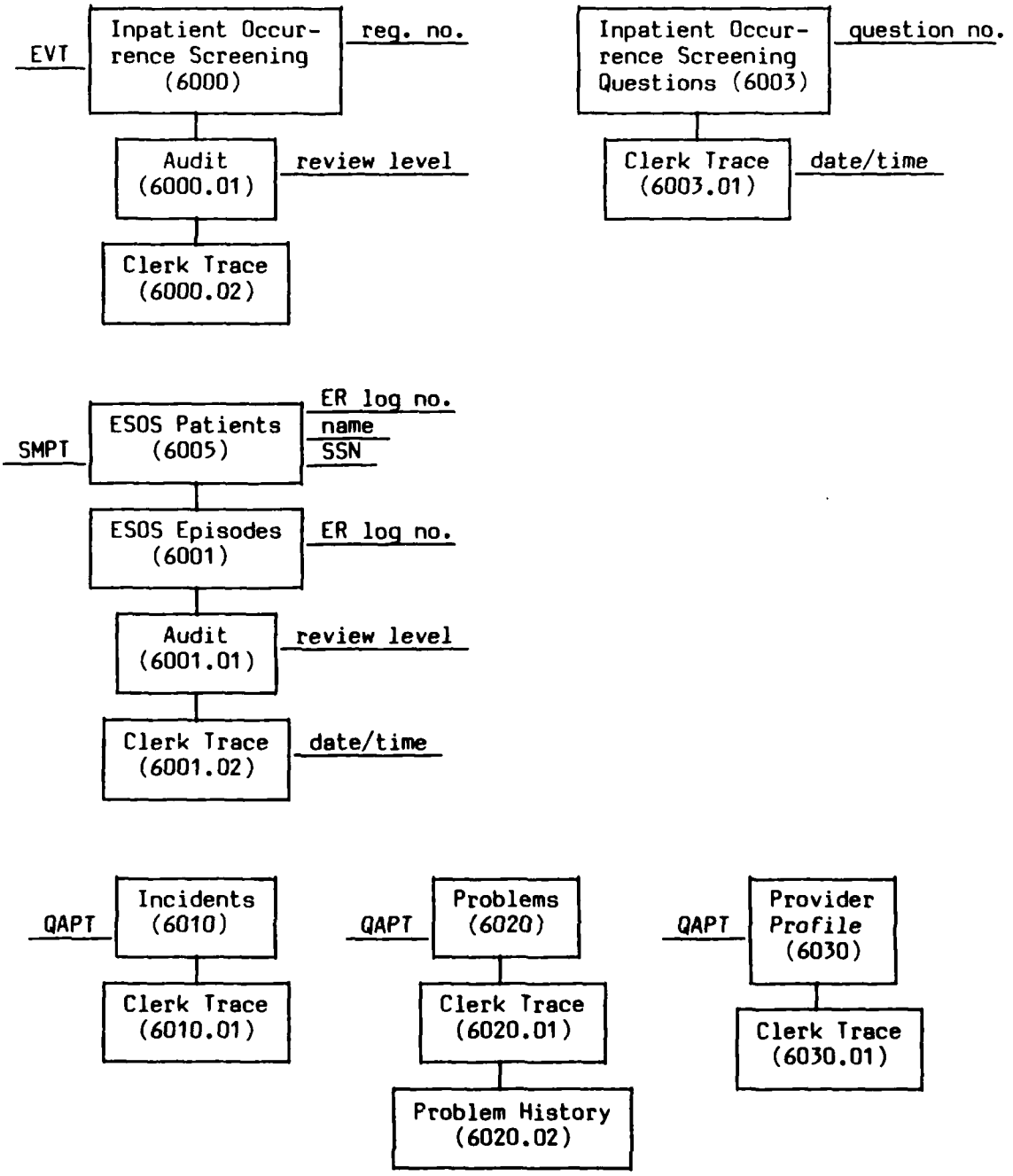

Figure 5-1. DATA BASE FORMAT (page 2 of 2)

Access Control Functions

User Entry
Patient Identification (PTID)

A&D (R/ADT) Subsystem

Registration
Admission
Disposition
Transfer
Correction Management
Bed Management
Inpatient History
Patient Inquiry
R/ADT Reports

System Management Function

Clinical Records Subsystem

Clinical Records
Clinical Records Reports

Quality Assurance Subsystem

Quality Assurance
Profiling

Figure 5-2. AQCESS SUBSYSTEMS AND FUNCTIONS

Also for security reasons, screens will time out, or disappear from the terminal, if they are displayed longer than a certain time without any data or commands entered. The length of time before timing out varies from function to function, because some functions are more sensitive than others, and is set by the System Manager through the System Management process.

5.4 Display and Retrieval Procedures. Screens are displayed when they are selected by the user from any menu or sub-menu in the system, or when the course of processing indicates that display of a screen should be automatic. In both cases, screen display can be considered immediate.

For examples of the AQCESS screens, see Part 1 of each of the following: Appendix A (A&D subsystem), Appendix B (System Management function),

Appendix C (Clinical Records subsystem), and Appendix D (Quality Assurance subsystem).

The different responses that users can make to displays vary depending on which of the almost 100 system screens is being displayed, and depending on the unique combination of data that has been entered on a patient record. Thus the number of these responses can almost be considered infinite.

5.5 Recovery and Error Correction Procedures. For a list of the error codes that the system can display, see Appendix H, Error Codes. Procedures to be followed in correcting the errors represented by these codes vary with each error and with the particular circumstances surrounding it.

5.6 Termination Procedures. The user terminates processing by cancelling or pressing the Return key on the keyboard until the User Entry Sign-On Screen is redisplayed.

SECTION 6. TERMINAL DATA UPDATE PROCEDURES

6.1 Frequency. Users may update data whenever there is a change to th information entered through their functional area(s).

6.2 Restrictions. If a user is authorized to access data via a system function, in most cases the user is also authorized to update the data available through that function at any time. A few data elements cannot be updated through some functions (e.g., the source of admission can only be changed in Correction Management, and not through Admission processing). If the user attempts to update such a data element through an inappropriate function, the system will display an error message and will not accept the entry.

6.3 Sources. The source of the data that makes up the updates is the same as the source of the data that makes up the original input. See Section 2.7.a.4 of this document.

6.4 Access Procedures. The user accesses a function through which he or she is authorized to perform updates in the same manner as described in Section 5.3.

6.5 Update Procedures. Update procedures are the same as procedures for data entry, except that the user accesses the field or fields to be updated by typing in all or part of the field label, or by entering "ALL" to update all allowed fields on the screen. When the updated data has been entered, the user presses the Return key to store it.

6.6 Recovery and Error Correction Procedures. Update data undergoes the same edits as initially entered data. A list of the possible resulting error codes is contained in Appendix H, Error Codes. For information about error correction and recovery procedures, see Section 3.5 of this document.

6.7 Termination Procedures. See Section 5.6.

Appendix A

A&D (R/ADT) INPUTS AND OUTPUTS

Part 1. A&D INPUTS (SCREENS)

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INTRODUCTION TO PART 1

Part 1 of this Appendix contains examples of screens used by the A&D subsystem of AQCESS. Screens are grouped by A&D function, as shown on the table of contents.

In most cases the screen is followed by a Data Chart that describes its fields and gives the number of the table in which the possible entries can be found. For fields where you enter data, these descriptions also give the number of characters allowed and indicate which fields are required (see below). Data Charts are not presented for menu screens, identification screens (which consist of only one data field, such as REGISTER NUMBER), and any screens that do not contain data fields.

Required and Allowed Fields. Data Charts state which data items are used by some military departments, but not all. They also specify which fields you are required to enter data in. A symbol appears in boldface after the description of a particular item to indicate whether that item is allowed or required. These symbols are as follows:

A	= allowed in the Army only, but not required
F	= allowed in the Air Force only, but not required
N	= allowed in the Navy only, but not required
A*	= required for Army patients
F*	= required for Air Force patients
N*	= required for Navy patients
DEP	= allowed for dependents
DEP*	= required for dependents
AD	= allowed for active-duty patients
AD*	= required for active-duty patients
**	= required for all patients.

These symbols are combined where it is necessary to be more specific, for example:

A,F	= allowed for Army and Air Force patients
A-DEP	= allowed for Army dependents
F*-AD	= required for Air Force active duty.

Required or allowed fields for other types of patients (for example, retired sponsors) are expressed in English.

Any symbol that indicates that a data field is allowed for a particular military department means that it is not allowed for any other. **A,F** means the data item can only be used in the Army and Air Force. If there is no symbol for a data item, you can assume that you are allowed to enter it for any military department. Also, remember that being allowed to use a data item does not mean you are required to use it.

Common Patient Data. A number of data fields related to patient identification, registration, and admission are used on more than one of the A&D screens. These fields are described in a basic Data Chart on the following pages. Later charts for specific screens may refer to this Basic Data Chart, rather than repeat detailed explanations of these fields.

(1) REGISTER NUMBER. 7-digit number assigned to the inpatient episode during admission. For Air Force newborns, the mother's register number is used, followed by a 1-letter alphabetical suffix--i.e., A for a single birth or for the first of a multiple birth, B for the second of a multiple birth, etc.

(2) PATIENT NAME. Name of the patient, in the following format: last name, followed by comma, followed immediately by first name. First name can be followed by a space and a middle initial or middle name, and/or a space and a title. Last name can contain hyphens or an apostrophe, but no other punctuation; first name and middle name can contain hyphens but no other punctuation.

(3) FMP. Patient's family member prefix. An FMP of 20 means that the patient is a sponsor. If the patient is not a sponsor, FMP indicates the relationship of the patient to the sponsor. See Table 1012 for codes.

(4) SSN. Social Security Number of patient's sponsor (or of patient if patient is the sponsor).

(5) DOB. Patient's date of birth.

(6) SEX. Code for the patient's sex.

(7) RACE. Code for the patient's race. See Table 1024.

(8) RELIGION. Code for the patient's religious preference. See Table 1000.

(9) MARITAL STATUS. Code for the patient's marital status.

(10) RANK. Code for the patient's rank. See Table 1006.

(11) PATIENT CATEGORY. Indicates the service affiliation and the authorization classification that authorizes the patient's care. Table 1002.

BASIC DATA CHART
Showing Data Common to AQCESS A&D Screens

(12) SERVICE. Service affiliation for Air Force and Navy sponsors, and foreign officers. For Army officers, this field should contain the Army branch of service. All codes contained in Table 1023.

(13) SOURCE OF ADMISSION. The source or type of the patient's admission (e.g., "DIR" for "direct," "TFR" for "transfer"). Can be displayed as code or textual description, or both. Also referred to as "type" of admission. See Table 2001.

(14) ADMISSION DATE AND TIME. The day, month, and year of the patient's admission, and the time of day, in military time.

(15) CLINICAL SERVICE. The UCA clinical service code of the service to which the patient is assigned (e.g., internal medicine, obstetrics). Table 2005.

(16) WARD. The ID number of the ward to which the patient is assigned.

(17) LENGTH SVC. Length of time the patient has been on active duty. For Army and Air Force, enter year or use Table 2014. For Navy enter year and month (YYMM), from zero to 55 years, 11 months.

(18) ABSENT STATUS. Code for the patient's hospitalization status, e.g., BO (bed occupant), CL (on convalescent leave). Table 2002.

(19) TYPE CASE. Code indicating the type of medical case and its cause (e.g., disease, assault, battlefield injury, etc.). See Table 2004.

(20) CAUSE OF INJURY. The cause of the patient's injury, if the hospitalization is the result of injury. Table 2009.

(21) DISPOSITION TYPE. Code indicating the patient's disposition status at the end of hospitalization (e.g., discharged to duty or home). Table 2007.

(22) DISPOSITION DATE/TIME. Date and time when the patient left the hospital's care.

(23) MTF TRANSFERRED. Code for the MTF to which the patient transferred, if the patient transferred to another MTF. Table 1005, or, for Army, a constructed MTF code for non-Army MTFs.

BASIC DATA CHART (SCREENS)

Format for Entering Personal Names and Date/Time. Personal names are entered in the following format: last name, followed by comma, followed immediately by first name. The first name can be followed by a space and a middle initial or middle name, and/or a space and a title. The last name can contain hyphens or an apostrophe, but no other punctuation; the first name and middle name can contain hyphens but no other punctuation.

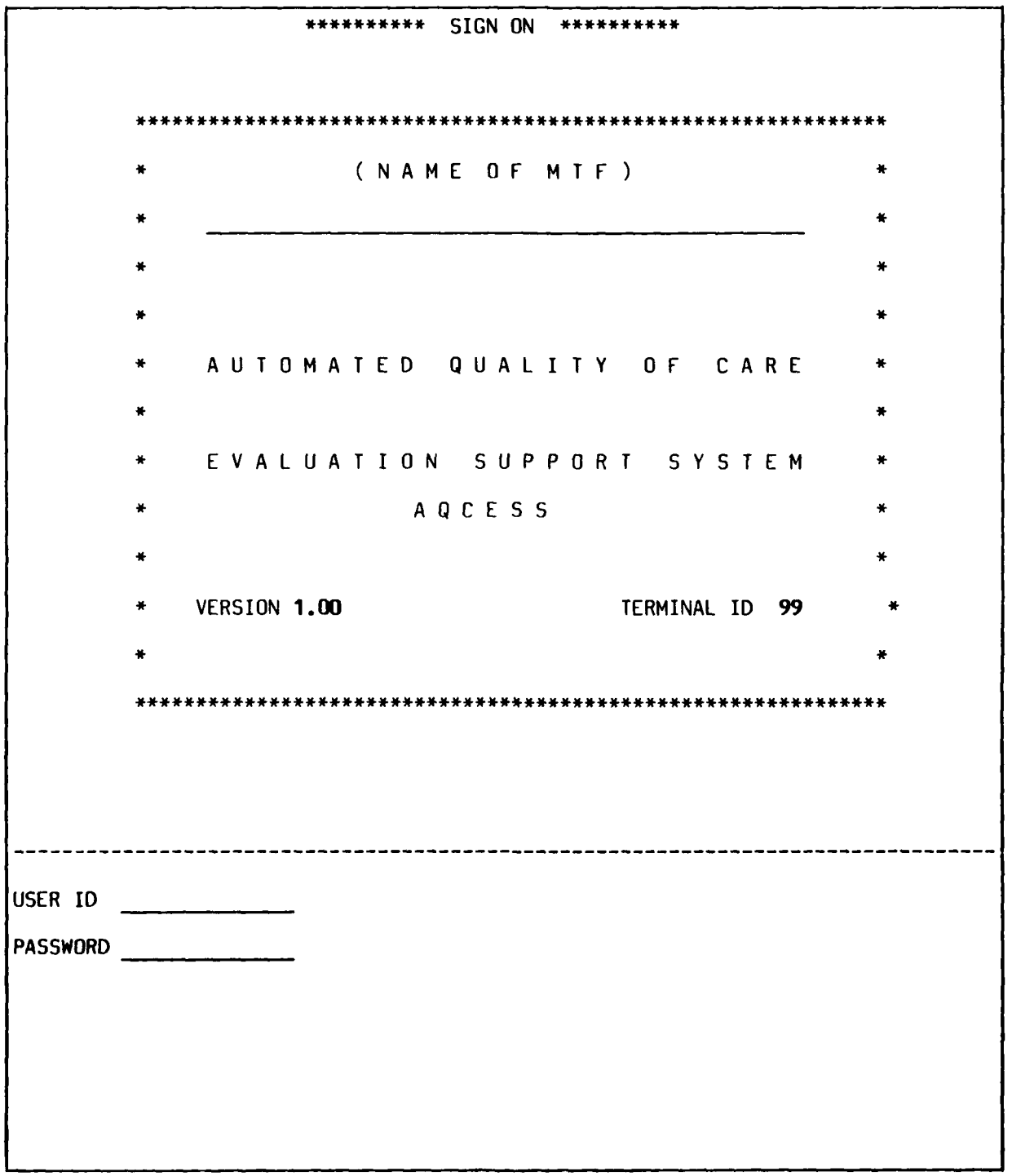
All dates can be entered in the following formats:

DDMMMYY	(e.g., 12JUN85)	MMDDYY	(e.g., 061285)
MMMDDYY	(e.g., JUN1285).		

Date, month, and year can be separated by a slash, comma, period, or space. The century can be added to the year. Whatever format is used to enter the date, the system will redisplay it in the format DD MMM YY (e.g., 12 JUN 85).

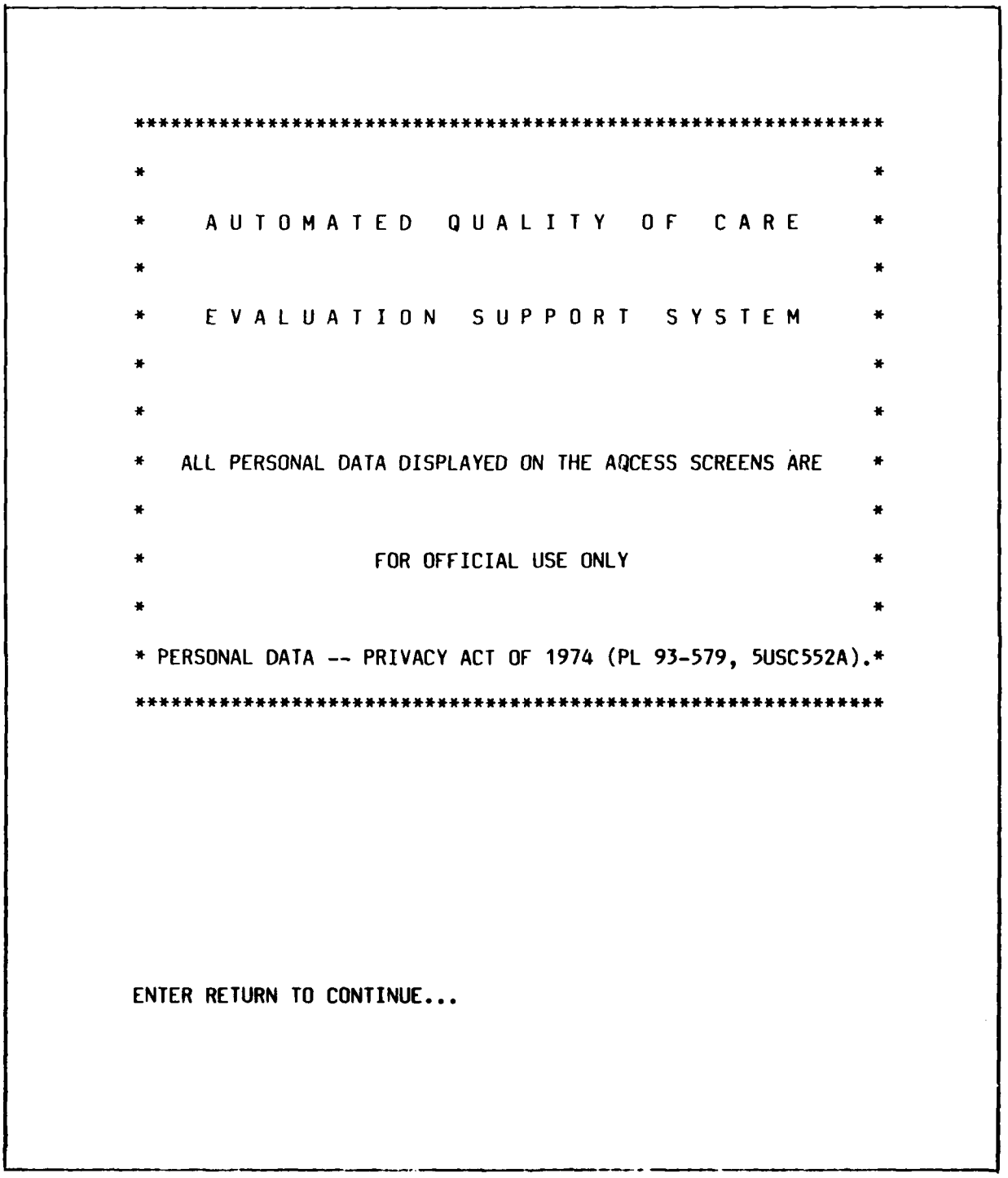
When entering the date and the time, enter the date as just described, followed by the @ sign, then the time, in military format.

A quick way to enter the present date is to enter T; the current date will be redisplayed on the screen. To enter both the present date and time, enter N, and that date and time will be redisplayed.



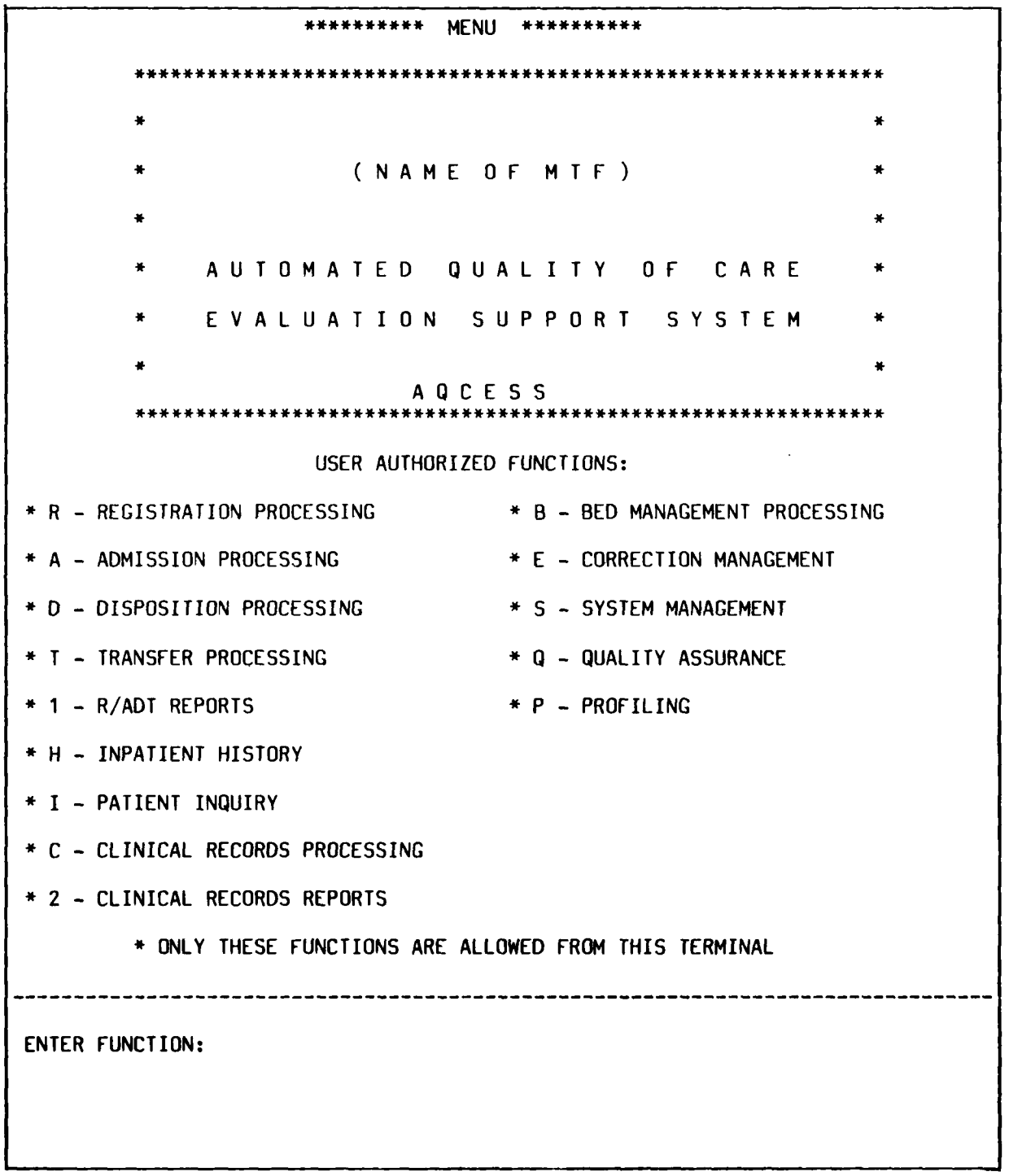
SIGN-ON SCREEN

UH007



PRIVACY ACT SCREEN

UH007



USER ENTRY MENU SCREEN

```
REGISTRATION                                          DATE __________ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974



          REG NO ________

          PATIENT NAME ____________________________

          FAMILY MEMBER PREFIX (FMP)  __

          SPONSOR'S SOCIAL SECURITY NUMBER (SSN)  __________

          DATE OF BIRTH  __________          SEX  _



          (N - NEW)          SELECTION _

-----------------------------------------------------------------------------
                          AVAILABLE SEARCHES

--------SEARCH TYPE------------          ----------FIELD ENTRY----------------

NAME FRAGMENT SEARCH                     ENTER PATIENT'S NAME OR PART OF NAME

SOUNDEX SEARCH                           ENTER ASTERISK(*) BEFORE LAST NAME

SOCIAL SECURITY NUMBER SEARCH            ENTER SPONSOR'S SSN
```

PTID SCREEN

For a new registration or admission, all fields on this screen are required except REG NO. You must also enter N after SELECTION.

(1) REG NO. The number assigned to the inpatient episode during the Admission process. 7 digits. 8th digit added in Air Force to indicate newborns. See the Data Chart for the Primary Admission Screen.

(2) PATIENT NAME. Last name first, followed by comma, followed immediately by first name. First name can be followed by a space and middle initial or middle name, and/or a space and a title. Last name can contain hyphens or apostrophe, but no other punctuation; first name and middle name can contain hyphens but no other punctuation. This is the format for all name fields in the system. 27 spaces available. When performing searches, full name need not be entered.

(3) FAMILY MEMBER PREFIX (FMP). A 2-character code indicating whether the patient is a sponsor, or the patient's family relationship to the sponsor. Table 1012.

(4) SPONSOR'S SOCIAL SECURITY NUMBER (SSN). The Social Security Number of the patient's sponsor (or of the patient if the patient is also the sponsor). 11 characters. Hyphens or slashes optional. SSN will be redisplayed with hyphens after it is entered.

(5) DATE OF BIRTH (DOB). Patient's date of birth. 11 characters. See the Introduction to Part 1 for information on entering dates.

(6) SEX. Patient's sex. 1 character.

DATA CHART - PTID SCREEN

```
REGISTRATION                                          DATE ___________ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974

LIST  NAME OF PATIENT        FMP   SSN         DOB        SEX  CURRENT/    REG
                                                                PREVIOUS    NO
                                                                  IND
0   ____________________  __  ________  __________  _     _      ________
1   ____________________  __  ________  __________  _     _      ________
2   ____________________  __  ________  __________  _     _      ________
3   ____________________  __  ________  __________  _     _      ________
4   ____________________  __  ________  __________  _     _      ________
5   ____________________  __  ________  __________  _     _      ________
6   ____________________  __  ________  __________  _     _      ________
7   ____________________  __  ________  __________  _     _      ________
8   ____________________  __  ________  __________  _     _      ________
9   ____________________  __  ________  __________  _     _      ________

-----------------------------------------------------------------------------
[  0 - _ ] PATIENT SELECTED                                  N - VIEW NEXT PAGE


ENTER SELECTION:
```

CANDIDATE LIST SCREEN

The data fields on this screen are for display only; you cannot update them.

(1) LIST NUMBER. Shows the order in which the record is listed on this screen (from 0 to 9). The user enters this number at ENTER SELECTION to choose a record to process.

(2) NAME OF PATIENT. The patient's name as it was entered on PTID Screen.

(3) FMP. Patient's family member prefix. Indicates the relationship between the sponsor and the patient. Table 1012.

(4) SSN. Social Security Number of patient's sponsor.

(5) DOB. Patient's date of birth.

(6) SEX of patient.

(7) CURRENT/PREVIOUS IND. Indicates whether the patient is a current inpatient or was an inpatient previously.

(8) REG NO. Register number of the patient's most recent hospital episode, or the code PREADM if the patient has been preadmitted.

DATA CHART - CANDIDATE LIST SCREEN

REGISTRATION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ FMP __ SSN _____ DOB _____

PATIENT: ADDRESS _____ ZIP CODE _____

CITY _____ STATE __ PHONE:HOME _____

HOME STATE __ WORK _____

PATIENT: CATEGORY ___ SEX _ MARITAL STATUS _ RACE _ RELIGION ___

PRIMARY CARE PROVIDER _____ PRIMARY MTF _____ CMD INTEREST ___/___/___

ID CARD EXP _____ CARD NO _____

MILITARY SPECIALTY _____ FLY STATUS __ AERO RING _

CIVILIAN OCCUPATION _____

REMARKS _____

SPONSOR: NAME _____ RANK ___ SERVICE __ MAJOR CMD ___

DUTY ADDRESS _____ ZIP CODE _____

CITY _____ STATE __ UNIT ID/SHIP _____

IS PATIENT REGISTRATION DATA VERIFIED ___ DATE VERIFIED _____

---

1 - REGISTRATION PRODUCTS 3 - VIEW REG HISTORY DATA

2 - VERIFY ESSENTIAL DATA 4 - RETURN TO SPONSOR DATA

ENTER SELECTION:

PRIMARY REGISTRATION SCREEN

Line 3 displays patient data entered on PTID Screen.

(1) PATIENT: ADDRESS. Street name and number, and apartment number, of patient's home. **N*-DEP. Also required for Navy non-active-duty sponsors.** 28 characters.

(2) ZIP CODE. The patient's zip code. If user enters a zip code that is on the MTF's zip code table, the CITY and STATE fields will default to the city and state associated with that zip code on the table. Table 1025. **DEP* and required for Navy non-active-duty sponsors.** 9 spaces available.

(3) CITY. The city in which the patient lives. **N-DEP* and required for Navy non-active-duty sponsors.** 20 characters.

(4) STATE. 2-letter abbreviation for the state in which the patient lives (listed in Table 1015). **N*-DEP and required for Navy non-active-duty sponsors.**

(5) PHONE: HOME. Patient's home telephone number, area code first, followed by 7-digit number, with 4-digit extension, if any. 7-19 characters.

(6) HOME STATE. The state of residence. Table 1015. 2 characters. **A**

(7) WORK. Patient's business or day telephone number. In the same format as for home phone number. Can include autovon number for military patients. 7-19 characters.

(8) PATIENT: CATEGORY. Code indicating the service affiliation and the authorization classification that authorizes care. Table 1002. **

(9) SEX. Patient's sex. 1 character. **

(10) MARITAL STATUS. Patient's marital status. 1 character. **

(11) RACE. Patient's race. Table 1024. 1 character. **

(12) RELIGION. Patient's religious preference. Table 1000. 3 spaces.

(13) PRIMARY CARE PROVIDER. Short name for the patient's primary health care provider. Table 1004. 6 characters.

(14) PRIMARY MTF. Code for the primary medical treatment facility that cares for the patient. Table 1005. Up to 6 characters.

(15) CMD INTEREST. Code indicating a special category or type of patient. Up to 3 3-character codes can be entered. Table 1016.

DATA CHART - PRIMARY REGISTRATION SCREEN

(16) ID CARD EXP. Date on which the patient's ID card expires. Can enter INDEF for "indefinite."

(17) CARD NO. Patient's military identification card number. 10 spaces. **N-DEP**

(18) MILITARY SPECIALTY. Code indicating the service member's military specialty. Table 1029. 5 spaces available. **AD***

(19) FLY STATUS. Patient's flying status or aviation service code. Table 1014. 2 spaces available. **A*-AD**

(20) AERO RTNG. Patient's aeronautical rating code. Table 1009. 1 character. **A*-AD**

(21) CIVILIAN OCCUPATION. Occupation of patient if not active-duty military. 25 spaces available.

(22) REMARKS. User can enter up to 70 characters of free-text remarks about the registration in this field.

SPONSOR DATA SEGMENT

(23) SPONSOR: NAME. *Name of the patient's military sponsor.* If the patient is a sponsor (i.e., the FMP = 20) this field will default to the patient's name. 27 spaces available. **

(24) RANK. Rank of sponsor. Table 1006. 3 spaces. **

(25) SERVICE. Military department. **Required for all Navy and Air Force sponsors and Army foreign military. Army branch of service required in this field for active-duty Army officers.** 2 spaces. Table 1023.

(26) MAJOR CMD. Identity of sponsor's major command. Table 1017. 3 characters. **F*-AD**

(27) DUTY ADDRESS of sponsor. The unit to which the sponsor is assigned. 28 spaces available.

(28) ZIP CODE of the sponsor's military unit. *If entry is from zip code* table, the CITY and STATE fields will default to the city and state associated with the zip code on the table. Table 1025. **Required for Army and Air Force sponsors.** 9 spaces available.

(29) CITY. The post, base, or military installation where the sponsor's unit is located. 20 spaces available.

DATA CHART - PRIMARY REGISTRATION SCREEN

(30) STATE. The state where sponsor's military unit is located. Table 1015. 2 characters.

(31) UNIT ID/SHIP. The unit's ID. 7 digits. **N*-AD**

(32) IS PATIENT REGISTRATION DATA VERIFIED? "YES" displayed in this field means that the patient or the patient's agent has verified this registration data as correct, and that all the data that is required for verification has been filled in.

More data is required to verify a registration than to simply enter the the registration on the system, and these required fields vary for each military department. The fields required to verify a registration are as follows:

Field	Service
Patient street address	A, F, N
Patient zip code	A, F, N
City	A, F, N
State	A, F, N
Patient category	A, F, N
Sponsor rank	A, F, N
Sponsor military department or branch of service	A, F, N
Duty address	A, F, N
Duty zip code	A, F, N
Duty city	A, F, N
Duty state	A, F, N
Sex	A, N
Race	A, N
ID card date	A, N
Unit ID/ship	A, N (except for retired or deceased sponsors)
Home phone	A, F
Work phone	A, F
Civilian occupation	A, F (if patient has a civilian patient category)
Home state	A
Marital status	A
Religion	A
Flying status	A
Primary care provider	A
Primary MTF	F

(33) DATE VERIFIED. Date on which the registration data was verified.

DATA CHART - PRIMARY REGISTRATION SCREEN

```
REGISTRATION                                          DATE ___________ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974

NAME ___________________________   FMP __   SSN ___________   DOB ___________

PATIENT: ADDRESS___________________________   ZIP CODE _________

         CITY ____________________   STATE __   PHONE:HOME ____________________

         HOME STATE __                              WORK ____________________

PATIENT: CATEGORY ___   SEX _   MARITAL STATUS _   RACE _   RELIGION ___

PRIMARY CARE PROVIDER ______   PRIMARY MTF _____   CMD INTEREST ___/___/___

                         ID CARD EXP _________   CARD NO ___________

                         *** REGISTRATION PRODUCTS ***

NUMBER OF REG FORMS REQUESTED _

 ------------------------------------------------------------------------------

       1 - REGISTRATION PRODUCTS        3 - VIEW REG HISTORY DATA

       2 - VERIFY ESSENTIAL DATA        4 - RETURN TO SPONSOR DATA

 ENTER SELECTION:
```

REGISTRATION PRODUCTS SEGMENT

(1) NUMBER OF REG FORMS REQUESTED. Enter the number of Registration Forms you want printed (up to 9).

DATA CHART - REGISTRATION PRODUCTS SEGMENT

REGISTRATION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ FMP __ SSN _____ DOB _____

PATIENT: ADDRESS _____ ZIP CODE _____

CITY _____ STATE __ PHONE:HOME _____

HOME STATE __ WORK _____

PATIENT: CATEGORY ___ SEX _ MARITAL STATUS _ RACE _ RELIGION ___

PRIMARY CARE PROVIDER _____ PRIMARY MTF _____ CMD INTEREST ___/___/___

ID CARD EXP _____ CARD NO _____

*** REGISTRATION HISTORY DATA ***

LAST INPATIENT ADMISSION _____ LAST INPATIENT DISPOSITION _____

CURRENT REG NO _____ PREVIOUS REG NO _____

DATE OF LAST REGISTRATION DATA UPATE _____

---

1 - REGISTRATION PRODUCTS 3 - VIEW REG HISTORY DATA

2 - VERIFY ESSENTIAL DATA 4 - RETURN TO SPONSOR DATA

ENTER SELECTION:

REGISTRATION - HISTORY DATA SEGMENT

All data displayed on this segment is defaulted by the system; user cannot update it.

(1) LAST INPATIENT ADMISSION. Date on which the patient was last admitted to the MTF.

(2) LAST INPATIENT DISPOSITION. Date on which the patient was last dispositioned from the MTF.

(3) CURRENT REG NO. of the patient.

(4) PREVIOUS REG NO. Patient's register number for the last inpatient episode.

(5) DATE OF LAST REGISTRATION DATA UPDATE. Date on which the registration data was updated.

DATA CHART - REGISTRATION HISTORY DATA SEGMENT

```
ADMISSION                                                  DATE ___________ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974

NAME ____________________________ ___ FMP __ SSN ___________ DOB ___________

PATIENT CATEGORY ___      SEX _     RELIGION ___     CMD INTEREST __/__/__

SOURCE ADM ___      REG NO ________   ADM DATE/TIME ________________

ATTENDING PHY ______ DATE ___________ CLIN SVC ____ DATE/TIME ___________

WARD ___ ROOM _______ BED __ DATE/TIME ________________ TYPE CASE ___

ADM DIAG: CODE _______ TEXT ____________________________________________

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS ___________ LENGTH SVC ____

                        *** ENTRANCE DATA ***

ADMITTING PHYSICIAN ______                                  CLERK ___

PREVIOUS ADM ___              PROJECTED DISP:  TYPE ____    DATE ___________

ADM REMARKS ____________________________________________________________

MEAL CARD _

HR _  DR _  SR _  PR _  OR _  PE _

 ---------------------------------------------------------------------------

      1 - INPATIENT PRODUCTS          3 - RETURN TO ENTRANCE

      2 - VIEW NEXT SEGMENT           4 - SELECTION TABLE

ENTER SELECTION:
```

PRIMARY ADMISSION SCREEN

Lines 3 and 4 display data entered on the PTID and Registration Screens.

(1) SOURCE ADM. 3-character code for the type of this inpatient admission (e.g., "DIR" for "direct," "TFR" for "transfer"). Table 2001. **

(2) REG NO. The 7-digit number that uniquely identifies the record of this inpatient episode. The MTF designates, through System Management, whether register numbers are to be assigned automatically by the system or manually by the user. If the automatic register number flag in System Management is set to "yes," the REG NO field will display a register number when the primary Admission Screen is displayed for a new admission. (In some situations, this number can be overridden; see Register Number Maintenance in System Management.) If the automatic register number flag is set to "no," no register number will be displayed in this field, and the user will type in the register number.

The register number for newborn Air Force patients is the mother's register number, entered manually, with a suffix (A for a single birth or for the first of a multiple birth, B for the second of a multiple birth, etc.).

(3) ADM DATE/TIME. Date and time of the admission. 16 spaces. ** Enter these as described in the Introduction to Part 1.

(4) ATTENDING PHY. Short name for the physician attending this patient. Table 1004. 6 spaces available. **Required for bed occupants.**

(5) DATE when the attending physician began treatment of the patient. Defaults to the date in the ADM DATE/TIME field for new admissions. **Required for bed occupants.**

(6) CLIN SVC. UCA code designating the clinical service to which the patient was assigned. Table 2005. 4 spaces available. **

(7) DATE/TIME when the clinical service assignment was made. Defaults to the admission date/time for new admissions. **

(8) WARD. ID of ward to which patient was assigned. 4 spaces available. **Required for bed occupants.**

(9) ROOM. Number of patient's room. 6 spaces available.

(10) BED. Number of the bed to which the patient is assigned. 3 spaces.

(11) DATE/TIME when the patient was assigned to a ward, room, and bed. Defaults to the admission date/time for new admissions. **Required for bed occupants.**

DATA CHART - PRIMARY ADMISSION SCREEN

(12) TYPE CASE. Code indicating the type of medical case and its cause (e.g., disease, battlefield injury, etc.). 3 spaces. Table 2004. **

(13) ADM DIAG: CODE. The International Classification of Diseases code that indicates the diagnosis made at admission. 5 spaces. Table 9001.

(14) TEXT. The textual description of the diagnosis made at admission. Defaults to the text description of the ICD code as it appears in the table, but this can be overridden. 50 spaces available.

(15) STATUS: ABSENT. Code indicating the hospitalization status of the patient (e.g., BO for bed occupant, CL for convalescent leave). Table 2002. Must be BO for mothers when admitting newborns, and patients with casualty statuses of SC, III, SCI, and VSI. **Required of all patients except preadmissions.**

(16) CASUALTY. Patient's casualty status. Indicates the seriousness of the patient's condition. 3 characters. Table 2011.

(17) MEB. 1-character code indicating patient's Medical Evaluation Board (MEB) status. Table 2010. **AD**

(18) EAOS/ETS. Expiration of term of service. The date on which the patient is to be released from service, if active duty. Can enter INDEF for "indefinite." 11 spaces available. **N-AD, A*-AD, F*-AD**

(19) LENGTH SVC. Length of time the patient has been on active duty. For Army and Air Force, enter year or use Table 2014. For Navy enter year and month (0000-5511). 4 spaces available. **AD***

ENTRANCE DATA SEGMENT

(20) ADMITTING PHYSICIAN. Short name of physician authorizing the admission. 6 spaces available. Table 1004.

(21) CLERK. Initials of clerk entering the admission. 3 characters. **

(22) PREVIOUS ADM. If patient has been admitted to this MTF before, this field should contain "Y" for "yes," and the year of the admission. For example, "Y83" means that the patient was admitted in 1983. "N" means the the patient has not been previously admitted to this facility. 3 spaces.

(23) PROJECTED DISP: TYPE. Code for the disposition type expected for this patient (e.g., returned to duty, transferred to another MTF). Table 2007. 4 spaces available.

DATA CHART - PRIMARY ADMISSION SCREEN

(24) DATE. The date when this patient is expected to be dispositioned. 11 spaces available.

(25) ADM REMARKS. 65 spaces available for free-text remarks about the admission.

(26) MEAL CARD. A "Y" in this field indicates that the patient has a meal card. 1 character. **F*-AD**

(27) HR, DR, SR, PR, OR, PE. A "Y" after any of these fields indicates that a record, or orders, or personal effects have been received for this patient. The fields are: HR = health record, DR = dental record, SR = service record, PR = pay record, OR = orders, PE = personal effects. **N**

DATA CHART - PRIMARY ADMISSION SCREEN

ADMISSION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST __/__/__

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** NEWBORN ADMISSION DATA ***

MOTHER'S REG NO _____

---

1 - INPATIENT PRODUCTS 3 - RETURN TO ENTRANCE

2 - VIEW NEXT SEGMENT 4 - SELECTION TABLE

ENTER SELECTION:

ADMISSION - NEWBORN ADMISSION SEGMENT

(1) MOTHER'S REG NO. For newborns, enter the mother's register number. 7 digits. **A, N**

DATA CHART - ADMISSION, NEWBORN ADMISSION SEGMENT

ADMISSION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST __/__/__

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** TRANSFER-IN DATA ***

INITIAL ADMISSION MTF ____ ADMISSION DATE _____

COUNTRY OF INITIAL ADMISSION __

---

1 - INPATIENT PRODUCTS 3 - RETURN TO ENTRANCE

2 - VIEW NEXT SEGMENT 4 - SELECTION TABLE

ENTER SELECTION:

ADMISSION - TRANSFER-IN SEGMENT

(1) INITIAL ADMISSION MTF. Code of the facility where the initial hospitalization for this episode took place. 4 digits. Table 1005, or, for Army, a constructed code for non-Army MTFs. **

(2) ADMISSION DATE. Date when the patient was admitted to the previous MTF. 11 digits. **

(3) COUNTRY OF INITIAL ADMISSION. Code of the country in which the previous MTF is located. Table 1015. 2 characters. A

DATA CHART - ADMISSION, TRANSFER-IN SEGMENT

ADMISSION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST __/__/__

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** EMERGENCY DATA ***

NEXT OF KIN: NAME _____ RELATION _____

ADDRESS _____ ZIP CODE _____

CITY _____ STATE __ PHONE _____

EMERGENCY: NAME _____ RELATION _____

ADDRESS _____ ZIP CODE _____

CITY _____ STATE __ PHONE _____

---

1 - INPATIENT PRODUCTS 3 - RETURN TO ENTRANCE

2 - VIEW NEXT SEGMENT 4 - SELECTION TABLE

ENTER SELECTION:

ADMISSION - EMERGENCY DATA SEGMENT

(1) NEXT OF KIN: NAME. Name of the legal next-of-kin to be notified for all changes in the patient's statuses. 27 characters available. **

(2) RELATION. Relationship of the next-of-kin to the patient. Table 2012. 12 spaces available.

(3) ADDRESS. Street name and number and apartment number of next-of-kin. 28 spaces available.

(4) ZIP CODE of next-of-kin. 9 spaces available.

(5) CITY of next-of-kin. 20 spaces available.

(6) STATE of next-of-kin. 2 characters.

(7) PHONE number of next-of-kin. 14 spaces available.

(8) EMERGENCY: NAME. Name of the person to be contacted in case of emergency regarding this patient. 27 characters available.

(9) RELATION. Relationship of the emergency contact to the patient. Table 2012. 12 spaces available.

(10) ADDRESS. Street name and number and apartment number of emergency contact. 28 spaces available.

(11) ZIP CODE of the emergency contact. 9 spaces available.

(12) CITY of the emergency contact. 20 spaces available.

(13) STATE of the emergency contact. 2 characters.

(14) PHONE number of the emergency contact. 14 spaces available.

DATA CHART - ADMISSION, EMERGENCY DATA SEGMENT

ADMISSION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST __/__/__

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** CAUSE OF INJURY DATA ***

MILITARY THEATER OF OPERATIONS __ ON DUTY FLAG _

CAUSE OF INJURY: (CODE) _ ___ (TEXT) _____

_____

---

1 - INPATIENT PRODUCTS 3 - RETURN TO ENTRANCE

2 - VIEW NEXT SEGMENT 4 - SELECTION TABLE

ENTER SELECTION:

ADMISSION - CAUSE OF INJURY SEGMENT

(1) MILITARY THEATER OF OPERATIONS. Code for the theater of operations in which the injury took place. Can be entered for non-injury cases. Table 2008. 2 characters. **N**

(2) ON DUTY FLAG. Indicates whether the injury occurred when the patient was on duty. 1 character. **N**

(3) CAUSE OF INJURY (CODE). Can contain 2 codes, as follows:

- Class of trauma. A description of the injury. Table 2016. 1 character. **F, N**
- Code for the cause of the patient's injury. 3 characters. Table 2009.

(4) (TEXT). Free text describing the injury and place where injury occurred. Defaults to the description of the cause of injury code entered, but this can be overridden. 120 characters available.

DATA CHART - ADMISSION, CAUSE OF INJURY SEGMENT

ADMISSION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST __/__/__

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** ABSENT STATUS DATA ***

ABS STATUS __ EFF DATE/TIME _____ RETURN DATE/TIME _____

FACILITY TYPE ___ COORD MED OFFICER _____

NON-MILITARY: NAME _____

ADDRESS _____ ZIP CODE _____

CITY _____ STATE __ PHONE _____

CIVILIAN PHYSICIAN: NAME _____ PHONE _____

---

1 - INPATIENT PRODUCTS 3 - RETURN TO ENTRANCE

2 - VIEW NEXT SEGMENT 4 - SELECTION TABLE

ENTER SELECTION:

ADMISSION - ABSENT STATUS SEGMENT

(1) ABS STATUS. Indicates the patient's hospitalization status. Defaults to the last absent status entered for the patient during this inpatient episode. Can be changed to other absent status except QT (quarters) or AS (absent sick). When you are entering a new admission who has an absent status of bed occupied, this segment will not automatically be displayed. Table 2002. 2 characters. **

(2) EFF DATE/TIME. Date and time when this absent status became effective. Defaults to admission date and time on a new admission. 16 characters available. **

(3) RETURN DATE/TIME. Date and time when patient who is absent from the MTF is expected to return. **Required for the following absent statuses:**

CL (convalescent leave)	PS (on pass)
SE (subsisting elsewhere)	TD (temporary duty/special duty)
QT (quarters)	

Not allowed for absent status of BD. Up to 16 spaces. Table 2002.

(4) FACILITY TYPE. Code indicating the type of facility in which an absent sick patient is located. Table 2015. 3 characters. **A**

(5) COORD MED OFFICER. Name of the health care provider coordinating the care of the absent patient. 26 spaces available.

(6) NON-MILITARY: NAME. Name of the non-military hospital where the absent patient is located. 27 spaces available.

(7) ADDRESS. Street name and number of non-military hospital. Up to 28 spaces.

(8) ZIP CODE of the non-military hospital. 9 spaces available.

(9) CITY of non-military hospital. 20 spaces available.

(10) STATE of non-military hospital. Table 1015. 2 characters.

(11) PHONE number of non-military hospital. 14 spaces available.

(12) CIVILIAN PHYSICIAN. Name of civilian physician attending the patient. 27 spaces available.

(13) PHONE number of civilian physician. 14 spaces available.

DATA CHART - ADMISSION, ABSENT STATUS SEGMENT

```
1  ADMISSION                                          DATE _____ TIME ____
2                        PERSONAL DATA - PRIVACY ACT OF 1974
3  NAME _____ ___ FMP __ SSN _____ DOB _____
4  PATIENT CATEGORY ___      SEX _     RELIGION ___      CMD INTEREST __/__/__
5
6  SOURCE ADM ___      REG NO _____      ADM DATE/TIME _____
7  ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____
8  WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___
9  ADM DIAG: CODE _____ TEXT _____
10 STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____
11
12                       *** CASUALTY STATUS DATA ***
13 CASUALTY STATUS ___                    PROGNOSIS __
14 CASUALTY DIAGNOSIS _____
15 DATE NEXT OF KIN LAST NOTIFIED _____ DATE STATUS CHANGE _____
16 DATE PLACED ON CASUALTY ROSTER _____ DATE REMOVED FROM ROSTER _____
17 DATE NOTIFIED HIGHER COMMAND _____
18 ------------------------------------------------------------------------
19       1 - INPATIENT PRODUCTS          3 - RETURN TO ENTRANCE
20       2 - VIEW NEXT SEGMENT           4 - SELECTION TABLE
21
22 ENTER SELECTION:
23
24
```

ADMISSION - CASUALTY STATUS SEGMENT

(1) CASUALTY STATUS. Code indicating the seriousness of the patient's condition. Table 2011. Defaults to the last casualty status entered for this patient during this inpatient episode, but you can override this. 3 characters. **

(2) PROGNOSIS. Code indicating patient's estimated recovery possibility. Table 2013. 2 characters. **

(3) CASUALTY DIAGNOSIS. Free text describing diagnosis. 25 spaces available. **

(4) DATE NEXT OF KIN LAST NOTIFIED about the casualty status. 11 spaces available.

(5) DATE STATUS CHANGE. Date showing any change in the status. Filled in automatically by the system. Can be updated. 11 spaces available.

(6) DATE PLACED ON CASUALTY ROSTER. Filled in by the system. Can be updated. 11 spaces available.

(7) DATE REMOVED FROM ROSTER. Date when status changed to non-casualty. Filled in automatically by system, and can be updated. Up to 11 spaces.

(8) DATE NOTIFIED HIGHER COMMAND. Date on which higher command was notified of the casualty status. Up to 11 spaces.

DATA CHART - ADMISSION, CASUALTY STATUS SEGMENT

ADMISSION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST ___/___/___

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** MEB STATUS DATA ***

MEB CANDIDATE _ DATE IDENTIFIED _____

DATE CONFIRMED _____ DATE RESOLVED _____

MEB REMARKS _____

---

1 - INPATIENT PRODUCTS 3 - RETURN TO ENTRANCE

2 - VIEW NEXT SEGMENT 4 - SELECTION TABLE

ENTER SELECTION:

ADMISSION - MEDICAL EVALUATION BOARD STATUS (MEB) SEGMENT

(1) MEB CANDIDATE. Single-character code indicating the Medical Evalua-Board status of the patient. Defaults to the last MEB status entered for this patient during this inpatient episode. If you enter "P" (potential candidate), the DATE IDENTIFIED field will default to the current date. If you enter "R" (resolved), the DATE RESOLVED field will default to the current date. Table 2010. 1 character. **AD**

(2) DATE IDENTIFIED. Date when an MEB status was first entered for this patient. 11 spaces available.

(3) DATE CONFIRMED. Date when an MEB status of "C" (confirmed) was entered. 11 spaces available.

(4) DATE RESOLVED. Date when a status of "R" (resolved) was entered. 11 spaces.

(5) MEB REMARKS. 65 spaces of free text available.

DATA CHART - ADMISSION, MEB STATUS SEGMENT

```
ADMISSION                                                DATE ___________ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974

NAME ___________________________ ___ FMP __ SSN ___________ DOB ___________

PATIENT CATEGORY ___      SEX _     RELIGION ___     CMD INTEREST ___/___/___

SOURCE ADM ___      REG NO ________   ADM DATE/TIME ______________

ATTENDING PHY ______ DATE ___________  CLIN SVC ____  DATE/TIME ___________

WARD ___  ROOM _______  BED __  DATE/TIME ___________________     TYPE CASE ___

ADM DIAG: CODE _______  TEXT ____________________________________________

STATUS: ABSENT __   CASUALTY ___ MEB _   EAOS/ETS ___________  LENGTH SVC ____

                        *** INPATIENT PRODUCTS ***

NUMBER OF INDEX CARDS REQUESTED _

NUMBER OF EMBOSSED CARDS REQUESTED _

NUMBER OF ADMISSION FORMS _

 ------------------------------------------------------------------------------

       1 - INPATIENT PRODUCTS          3 - RETURN TO ENTRANCE

       2 - VIEW NEXT SEGMENT           4 - SELECTION TABLE

ENTER SELECTION:
```

ADMISSION - INPATIENT PRODUCTS SEGMENT

(1) NUMBER OF INDEX CARDS REQUESTED. Enter the number of sets of Index Cards you want produced. These are the 3x5 Cards for the Army and Air Force, and the 5x8 Cards for the Navy. They are printed in sets; the number in a set is determined by your MTF. If the MTF has specified that a set = 2 and you enter 3 in this field, 6 cards will be produced. You can request up to 9 sets. One set is automatically produced on admission.

(2) NUMBER OF EMBOSSED CARDS REQUESTED. Not available at this time.

(3) NUMBER OF ADMISSION FORMS. Enter the number of Admission Forms or Admission Cover Sheets you want printed, up to 9. One form is automatically printed on admission.

DATA CHART - ADMISSION, INPATIENT PRODUCTS

```
ADMISSION                                                  DATE ___________ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974

NAME ____________________________ ___ FMP __ SSN ___________ DOB ___________

PATIENT CATEGORY ___      SEX _     RELIGION ___     CMD INTEREST ___/___/___

SOURCE ADM ___      REG NO ________   ADM DATE/TIME ______________

ATTENDING PHY ______ DATE ___________ CLIN SVC ____ DATE/TIME ___________

WARD ___ ROOM _______ BED __ DATE/TIME ________________ TYPE CASE ___

ADM DIAG: CODE _______ TEXT ____________________________________________

STATUS: ABSENT __   CASUALTY ___ MEB _   EAOS/ETS ___________ LENGTH SVC ____

-----------------------------------------------------------------------------

      5 - UPDATE NEWBORN ADMISSION DATA      9 - UPDATE ABSENT STATUS DATA

      6 - UPDATE TRANSFER-IN DATA           10 - UPDATE CASUALTY STATUS DATA

      7 - UPDATE EMERGENCY DATA             11 - UPDATE MEB STATUS DATA

      8 - UPDATE CAUSE OF INJURY DATA       12 - ADMISSION CANCELLATION

-----------------------------------------------------------------------------

      1 - INPATIENT PRODUCTS                 3 - RETURN TO ENTRANCE

      2 - VIEW NEXT SEGMENT                  4 - SELECTION TABLE

ENTER SELECTION:
```

ADMISSION - SELECTION TABLE SEGMENT

ADMISSION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST __/__/__

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** ADMISSION CANCELLATION ***

SOURCE ADM ___ CLERK ___

AUTHORIZING PHYSICIAN _____ DATE OF CANCELLATION _____

REASON FOR CANCELLATION _____

---

1 - INPATIENT PRODUCTS 3 - RETURN TO ENTRANCE

2 - VIEW NEXT SEGMENT 4 - SELECTION TABLE

ENTER SELECTION:

ADMISSION - ADMISSION CANCELLATION SEGMENT

(1) SOURCE ADM. Defaults to the last source of admission code entered for this patient. Enter an appropriate code (e.g., CAN to cancel an admission, PRE to change an admission to a preadmission). Table 2001. 3 characters. **

(2) CLERK. Initials of clerk entering data in this segment. Up to 3 characters. **

(3) AUTHORIZING PHYSICIAN. Short name for the physician authorizing the admission cancellation. Table 1004. Up to 6 characters. **

(4) DATE OF CANCELLATION. Up to 11 characters. **

(5) REASON FOR CANCELLATION. 50 spaces available for free text. **

DATA CHART - ADMISSION CANCELLATION SEGMENT

DISPOSITION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST ___/___/___

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** PATIENT DISPOSITION ***

DISPOSITION TYPE _____ DISPOSITION DATE/TIME _____

MTF TRANSFERRED _____ CLERK ___

PHYSICIAN ORDERING DISP _____ PHYSICIAN AUTHENTICATING DISP _____

---

1 - CANCEL DISPOSITION 2 - VIEW ADMISSION DATA

ENTER SELECTION:

PRIMARY DISPOSITION SCREEN

See the Data Chart for the Primary Admission Screen for descriptions of the data on the Admission Summary segment.

(1) DISPOSITION TYPE. Code indicating the patient's disposition status at the end of hospitalization. Table 2007. Up to 4 characters. **

(2) DISPOSITION DATE/TIME. Date and time when the patient left the hospital's care. Up to 16 spaces. Enter as described in the Introduction to Part 1. **

(3) MTF TRANSFERRED. If the disposition type indicates that the patient is transferring to another MTF, the code for that MTF is entered here. Table 1005, or for Army, a constructed code indicating a non-Army facility. Up to 6 characters. **Required for patients transferring out of this MTF.**

(4) CLERK. Initials of the clerk entering the disposition. 3 characters available. **

(5) PHYSICIAN ORDERING DISP. Short name for the physician ordering the disposition. Table 1004. Up to 6 characters. **

(6) PHYSICIAN AUTHENTICATING DISP. Short name for the physician who authenticates the disposition. Up to 6 characters. Table 1004.

DATA CHART - DISPOSITION, PATIENT DISPOSITION SEGMENT

DISPOSITION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST ___/___/___

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** NEWBORN DISPOSITION ***

REG NO _____ NAME _____ FMP __ DOB _____

DISPOSITION TYPE ____ DISPOSITION DATE/TIME _____

MTF TRANSFERRED _____ CLERK __

PHYSICIAN ORDERING DISP _____ PHYSICIAN AUTHENTICATING DISP _____

---

1 - DISPOSITION THIS NEWBORN 2 - PUT NEWBORN TO PAY STATUS

ENTER SELECTION:

DISPOSITION - NEWBORN DISPOSITION SEGMENT

If this segment appears automatically as a result of having dispositioned the mother, the infant's REGISTER NUMBER, NAME, FMP, and DOB are included. See the Basic Data Chart for descriptions.

The other fields on this segment are the same as on the Patient Disposition segment. To disposition the newborn, observe the following:

(1) DISPOSITION TYPE. Up to 4 characters. **

(2) DISPOSITION DATE/TIME. Defaulted to the disposition date/time entered for the mother, and cannot be changed.

(3) MTF TRANSFERRED. Code for MTF to which the newborn was transferred. Up to 6 characters. Table 1005, or, for Army, a constructed code indicating a non-Army MTF.

(4) CLERK. Defaulted to the clerk initials entered for the mother, but can be updated. Up to 3 characters.

(5) PHYSICIAN ORDERING DISP. Short name for the physician ordering the disposition. Table 1004. Up to 6 spaces. **

(6) PHYSICIAN AUTHENTICATING DISP. Short name for the physician authenticating the dispostion. Table 1004. Up to 6 spaces.

DATA CHART - DISPOSITION, NEWBORN DISPOSITION SEGMENT

DISPOSITION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST __/__/__

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** DISPOSITION CANCELLATION ***

WARD ___ ROOM ____ BED __ DATE/TIME _____

CANCEL DATE _____ AUTHORIZING PHYSICIAN _____ CLERK ___

REASON FOR CANCELLATION _____

---

1 - CANCEL DISPOSITION 2 - VIEW ADMISSION DATA

ENTER SELECTION:

DISPOSITION - DISPOSITION CANCELLATION SEGMENT

(1) WARD. ID of the ward from which the patient was dispositioned and to which the patient will be reassigned if the disposition is cancelled. Defaults to the last ward assignment for this patient.

(2) ROOM to which patient was assigned.

(3) BED to which patient was assigned.

(4) DATE/TIME when last ward assignment was made. Defaults but should be updated if the ward is changed.

(5) CANCEL DATE. Date on which the disposition is cancelled. Up to 11 spaces.

(6) AUTHORIZING PHYSICIAN. Short name for the physician authorizing the cancellation. Table 1004. Up to 6 spaces. **

(7) CLERK. Initials of the clerk entering the cancellation. Up to 3 characters.

(8) REASON FOR CANCELLATION. 50 spaces available for free text. **

DATA CHART - DISPOSITION CANCELLATION SEGMENT

DISPOSITION DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ ___ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST ___/___/___

SOURCE ADM ___ REG NO _____ ADM DATE/TIME _____

ATTENDING PHY _____ DATE _____ CLIN SVC ____ DATE/TIME _____

WARD ___ ROOM _____ BED __ DATE/TIME _____ TYPE CASE ___

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT __ CASUALTY ___ MEB _ EAOS/ETS _____ LENGTH SVC ____

*** NEWBORN DISP CANCELLATION ***

REG NO _____ NAME _____ FMP __ DOB _____

WARD ___ ROOM ____ BED __ DATE/TIME _____

CANCEL DATE _____ AUTHORIZING PHYSICIAN _____ CLERK ___

REASON FOR CANCELLATION _____

---

1 - CANCEL NEWBORN DISPOSITION 2 - LEAVE NEWBORN AS IS

ENTER SELECTION:

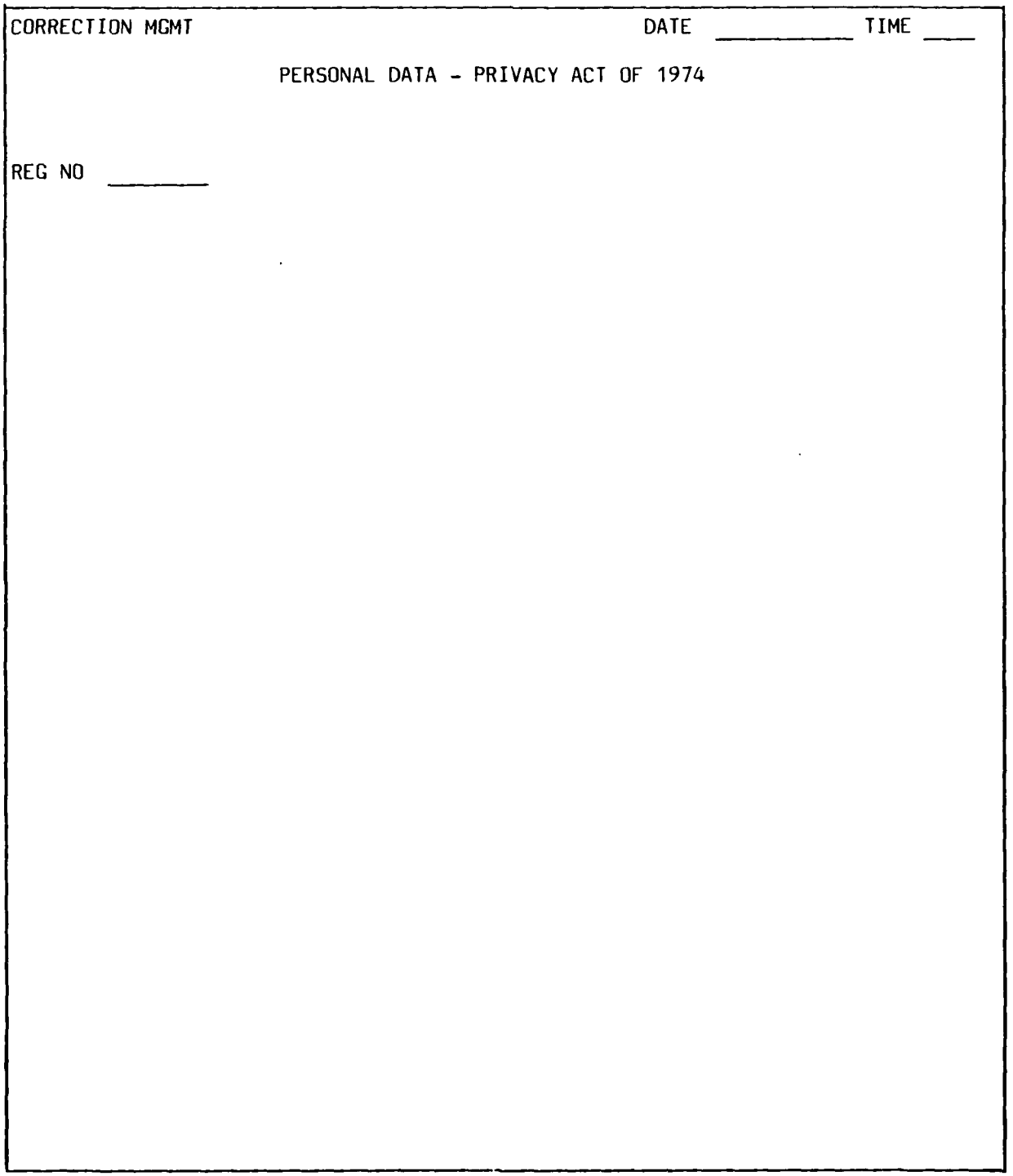
DISPOSITION - NEWBORN DISPOSITION CANCELLATION SEGMENT

This segment contains the same fields as the Disposition Cancellation Segment. The CLERK field defaults to the initials entered during cancellation of the mother's disposition, but can be overridden.

The AUTHORIZING PHYSICIAN and REASON fields are required for all newborn cancellations.

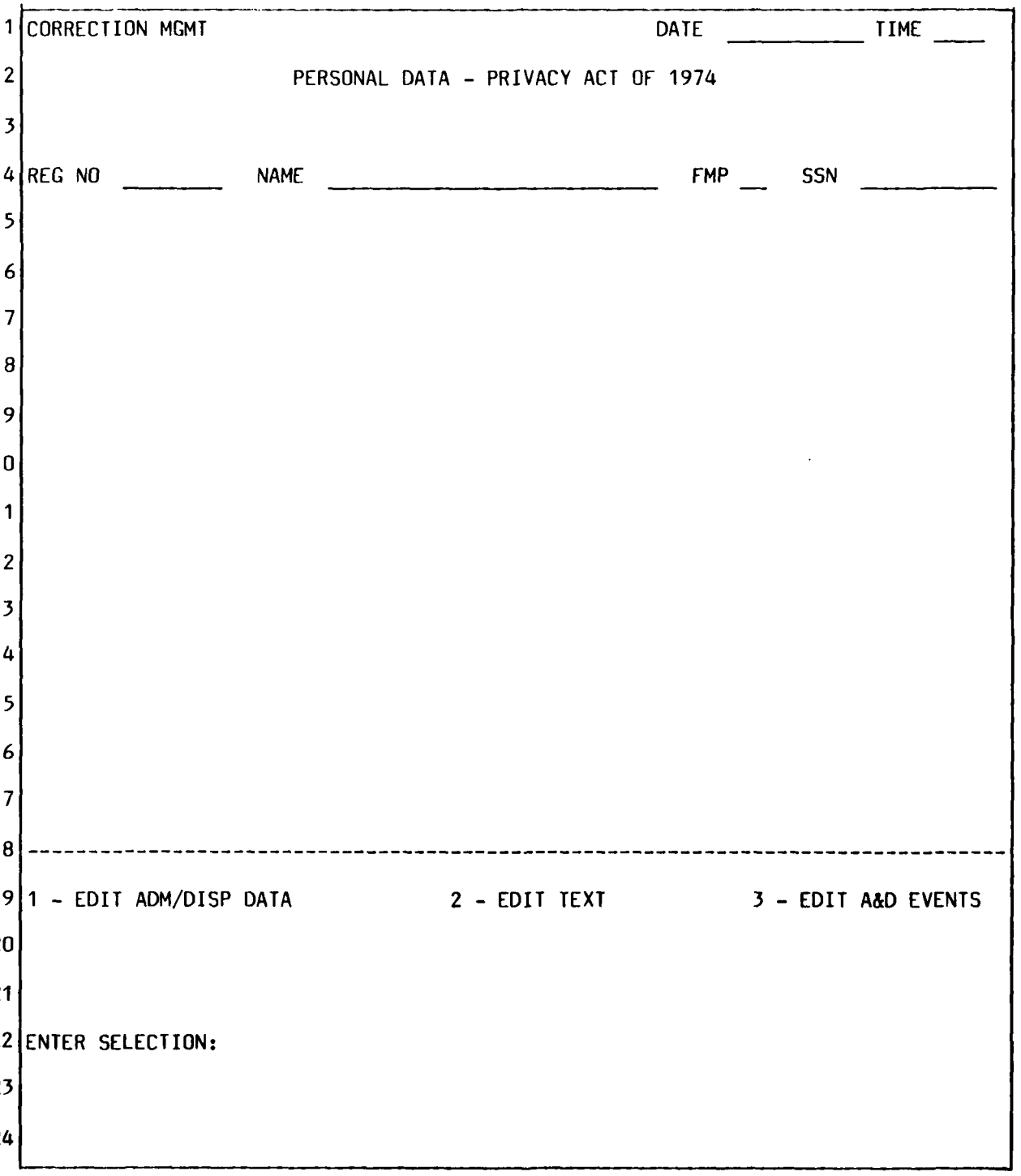
If this segment is displayed automatically as a result of having cancelled the mother's disposition, the infant's REGISTER NUMBER, NAME, FMP, and DOB are included. If the newborn is being retained, the SOURCE ADM field is displayed and must be filled in (3 characters; see the Basic Data Chart).

DATA CHART - DISPOSITION, NEWBORN DISPOSITION CANCELLATION SEGMENT



CORRECTION MANAGEMENT ID SCREEN

UH007



CORRECTION MANAGEMENT ID SCREEN, Showing Patient Data and Sub-Menu

```
CORRECTION MGMT                                    DATE ___________ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974

REG NO ________   NAME ___________________________   FMP __   SSN ___________

                    *** ADMISSION AND DISPOSITION DATA ***

 PATIENT CATEGORY    ___
 LENGTH OF SERVICE   ___
 SOURCE OF ADMISSION ___                    INITIAL ADM MTF   ____
                                            INITIAL ADM DATE  ___________
                                            COUNTRY OF ADM    __
                                      NEWBORN/MOTHER'S REG NO  ________
 ADMISSION DATE/TIME ___________
 DISPOSITION TYPE ___                 MTF TRANSFERRED TO  ____
 DISPOSITION DATE/TIME ________

-----------------------------------------------------------------------------
1 - EDIT ADM/DISP DATA          2 - EDIT TEXT          3 - EDIT A&D EVENTS



ENTER SELECTION:
```

CORRECTION MANAGEMENT - ADMISSION & DISPOSITION DATA SCREEN

Line 4 of the CM screens displays the register number and patient data that was entered in PTID or changed in Registration (see the Basic Data Chart).

When the A&D Data Screen appears, it displays data that was previously entered or updated through Admission, Transfer, or Disposition.

(1) PATIENT CATEGORY. 3 characters; Table 1002. See the Basic Data Chart.

(2) LENGTH OF SERVICE. For Army and Air Force, the number of years, or an entry from Table 2014. For Navy, the number of years and months (up to 55 years and 11 months). See the Basic Data Chart.

(2) SOURCE OF ADMISSION. The type of inpatient admission. Table 2001. 3 characters. Observe the following conditions on this screen:

- You cannot enter a source of admission of CRO or ERD, or a pay status code.
- If you change the source of admission to transfer-in, you must enter the related transfer-in data; see fields (3), (4), and (5), below.
- If you change the source of admission to newborn, you must enter the mother's register number in data field (6), below.

(3) INITIAL ADM MTF. Code of the facility from which the patient transferred. 4 spaces available. Table 1005, or for Army, a constructed code for non-Army MTFs.

(4) INITIAL ADM DATE. Date on which the patient was admitted to the MTF named in (3). Up to 11 spaces.

(5) COUNTRY OF ADM. Country in which the MTF-transferred-from is located. Table 1015. 2 characters. **A**

(6) NEWBORN/MOTHER'S REG NO. If patient is a newborn, this field shows the mother's 7-digit register number. If patient is a mother of a newborn, this field shows the newborn's register number. See the Data Chart for the Primary Admission Screen.

(7) ADMISSION DATE/TIME. 16 digits.

DATA CHART - CORRECTION MANAGEMENT, ADMISSION & DISPOSITION DATA SCREEN

(8) DISPOSITION TYPE. Type of the patient's disposition. Table 2007. Up to 4 characters. Observe the following conditions when updating on this screen:

- If the patient has not been dispositioned, you cannot enter a disposition code in this field.
- If the patient has been dispositioned, you cannot delete the disposition code here.
- If you change the disposition code to transfer-out, you must enter the code for the MTF-transferred-to in the next field.
- If you change the disposition code from transfer-out to something else, AQCESS will delete the code of the MTF-transferred-to.

(9) MTF TRANSFERRED TO. Code of the MTF to which the patient was transferred. Table 1005, or, for Army, a constructed code indicating a non-Army MTF. Up to 4 characters.

(10) DISPOSITION DATE/TIME. 16 digits.

DATA CHART - CORRECTION MANAGEMENT, ADMISSION & DISPOSITION DATA SCREEN

CORRECTION MGMT DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

REG NO _____ NAME _____ FMP __ SSN _____

*** A&D REPORT TEXT ***

	REPORT	EFFECT	TEXT MESSAGE:
0)			
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			

ENTER LINE NUMBER:

CORRECTION MANAGEMENT - REPORT TEXT SCREEN

This screen displays any notes that AQCESS has already generated for the next report, or that have already been entered on this screen. You can enter additional notes on this screen.

(1) REPORT. The date of the report on which the text will appear. When you create a text record, this will always be today's report. You cannot update this field.

(2) EFFECT. The date of the report to which the text refers. 7 characters.

(3) TEXT MESSAGE. The message that will appear on the report. 60 spaces available.

DATA CHART - CORRECTION MANAGEMENT, REPORT TEXT SCREEN

CORRECTION MGMT DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

REG NO _____ NAME _____ FMP __ SSN _____

LINE	EFF DATE/TIME	ABS STA	CLN SVC	OLD WARD	NEW WARD
0	_____	__	____	____	____
1	_____	__	____	____	____
2	_____	__	____	____	____
3	_____	__	____	____	____
4	_____	__	____	____	____
5	_____	__	____	____	____
6	_____	__	____	____	____
7	_____	__	____	____	____
8	_____	__	____	____	____
9	_____	__	____	____	____

N - NEXT PAGE OF CHANGES

ENTER LINE NUMBER:

CORRECTION MANAGEMENT - EVENT RECORD SCREEN

UH007

This screen displays the history of A&D events for this inpatient episode, in chronological order.

(1) LINE. The number of the event record. Enter the number of the record you want to change in the selection field. If you are inserting an event record, enter the number of the first blank line, and the effective date and time of the event.

(2) EFF DATE/TIME. The effective date and time of the event. 16 characters.

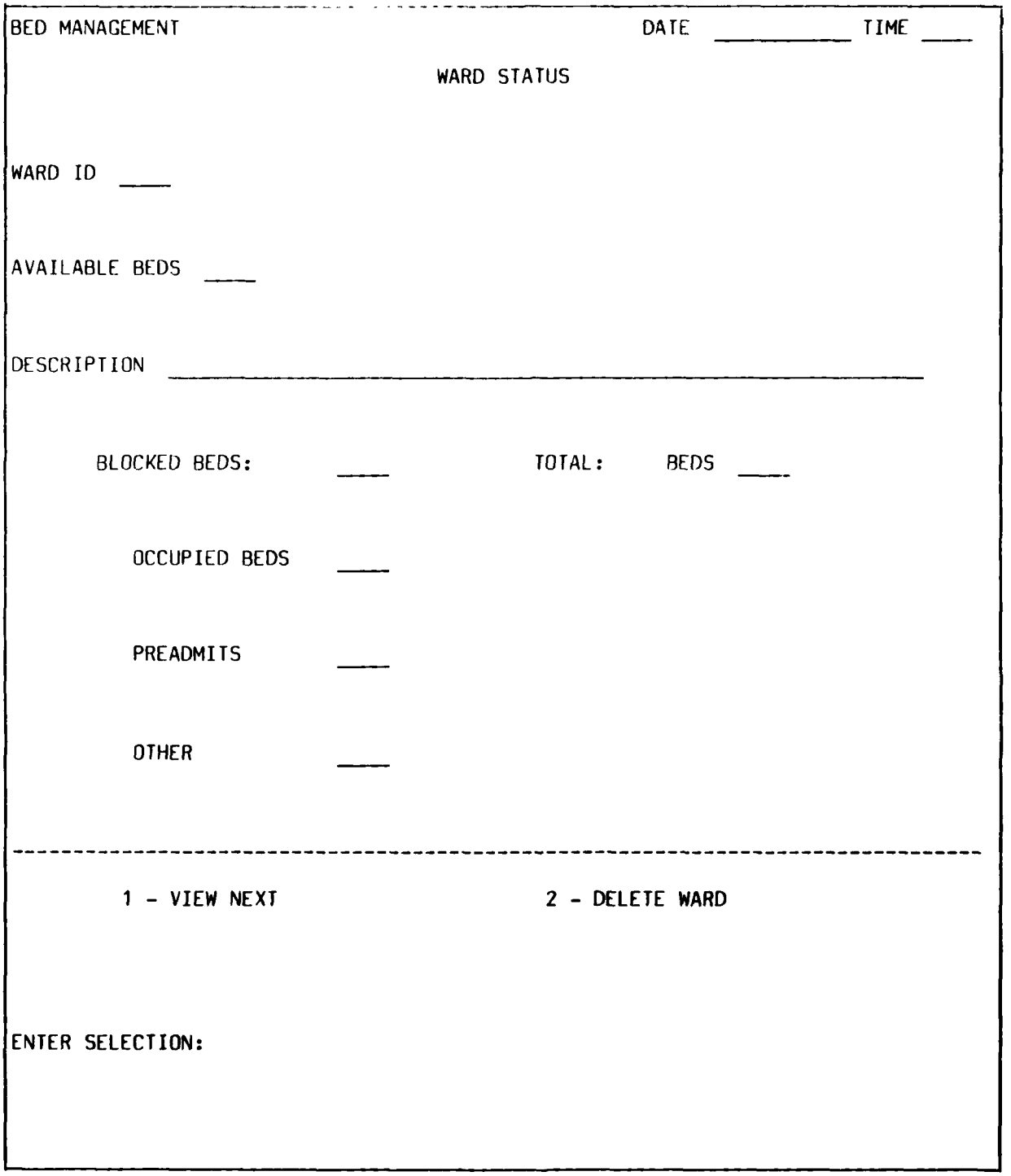
(3) ABS STA. The new (or first) absent status to which the patient was assigned. 2 characters. Table 2002.

(4) CLN SVC. The new (or first) UCA clinical service code to which the patient was assigned. Up to 4 characters. Table 2005.

(5) OLD WARD. ID number of the ward the patient is leaving (whether transferring to another ward or leaving the MTF). 3 characters.

(6) NEW WARD. ID number of the ward the patient is transferring to. 3 characters.

DATA CHART - CORRECTION MANAGEMENT, EVENT RECORD SCREEN



BED MANAGEMENT SCREEN

UH007

+(1) WARD ID. ID number of the ward for which data is requested. Cannot be all numeric. Up to 4 characters. To see total bed availability figures for the entire MTF, enter TOT.

(2) AVAILABLE BEDS. Number of available beds on the ward. For display only.

+(3) DESCRIPTION. The name of the ward (e.g., pediatrics). 60 spaces of free text available.

(4) BLOCKED BEDS. Number of beds in use or temporaril, marked as unavailable. This figure is the sum of the number of occupied beds, beds reserved for preadmits, and otherwise unavailable beds ("OTHER"). For display only.

(5) OCCUPIED BEDS. Number of beds currently in use. For display only.

(6) PREADMITS. Number of beds reserved for preadmits. For display only.

+(7) OTHER. The number of beds that are unavailable for other reasons (e.g., broken beds). Up to 4 digits.

+(8) TOTAL: BEDS. The number of beds physically assigned to the ward. Up to 4 digits. **

+You can enter data in these fields when creating a new ward status records. The remaining fields cannot be updated.

DATA CHART - BED MANAGEMENT SCREEN

HISTORY DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ FMP __ SSN _____

LIST	REG NO	ADMISSION DATE	DISPOSITION DATE	ADM DIAG CD
0	_____	_____	_____	____
1	_____	_____	_____	____
2	_____	_____	_____	____
3	_____	_____	_____	____
4	_____	_____	_____	____
5	_____	_____	_____	____
6	_____	_____	_____	____
7	_____	_____	_____	____
8	_____	_____	_____	____
9	_____	_____	_____	____

[0 - _] PATIENT SELECTED N - VIEW NEXT PAGE

ENTER SELECTION:

INPATIENT HISTORY - EPISODE LIST SCREEN

This screen displays the following patient data: NAME, FMP, and SSN (see the Basic Data Chart). This screen is for display only; no data can be updated.

(1) LIST. The number of the inpatient episode. Enter the number of the episode you want in the selection field.

(2) REG NO. The register number assigned to this inpatient episode.

(3) ADMISSION DATE.

(4) DISPOSITION DATE.

(5) ADM DIAG CD. Code for the admission diagnosis for this episode. Table 9001.

DATA CHART - INPATIENT HISTORY, EPISODE LIST SCREEN

HISTORY DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ FMP __ SSN _____ DOB _____

PNT CAT ___ BRANCH SVC __ RANK ___ SEX _ RELIGION ___ RACE _

REG NO _____

ADM DATE TIME _____ CLINICAL SERVICE ____ WARD ____

SOURCE ADMISSION ___ ADMITTING DIAG CODE _____ TYPE CASE ___

DISP DATE/TIME _____ DISP TYPE ____ MTF _____

PRIMARY DISP DIAG _____ ATTENDING PHYSICIAN _____

PRIMARY PROCEDURE ____ ARCHIVE DATE _____

N - NEXT P - PREVIOUS

ENTER SELECTION:

INPATIENT HISTORY SCREEN

This screen is for display only; no data can be updated.

(1) NAME, FMP, SSN, DOB. See the Basic Data Chart.

(2) PNT CAT, BRANCH SVC, RANK, SEX, RELIGION, RACE. See the Basic Data Chart.

(3) REG NO, ADM DATE/TIME, CLINICAL SERVICE, WARD, SOURCE ADMISSION, ADMITTING DIAG CODE, TYPE CASE. See the Basic Data Chart. The ADMITTING DIAG CODE is the diagnosis code entered at admission, from Table 9001.

(4) DISP DATE/TIME, DISP TYPE, MTF (transferred to). See the Basic Data Chart.

(5) PRIMARY DISP DIAG. The first diagnosis entered on the Diagnosis Screen in Clinical Records. Table 9001.

(6) ATTENDING PHYSICIAN. The attending or primary physician entered on the Miscellaneous Screen in Clinical Records.

(7) PRIMARY PROCEDURE. The first procedure entered on the Procedure Screen in Clinical Records. Table 9002.

(8) ARCHIVE DATE. The date on which this record was archived.

DATA CHART - INPATIENT HISTORY SCREEN

PATIENT INQUIRY DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

LOOK-UP BY: _____

PATIENT INQUIRY LOOK-UP SCREEN

UH007

(1) LOOK-UP BY. Enter the word for the category for which you would like to see patients listed. Use HELP to find out what categories your MTF uses. Up to 20 characters.

DATA CHART - PATIENT INQUIRY LOOK-UP SCREEN

```
R/ADT REPORTS                                    DATE _____ TIME ____

  NUMBER   REPORT TITLE
-------------------------------------------------------------------------

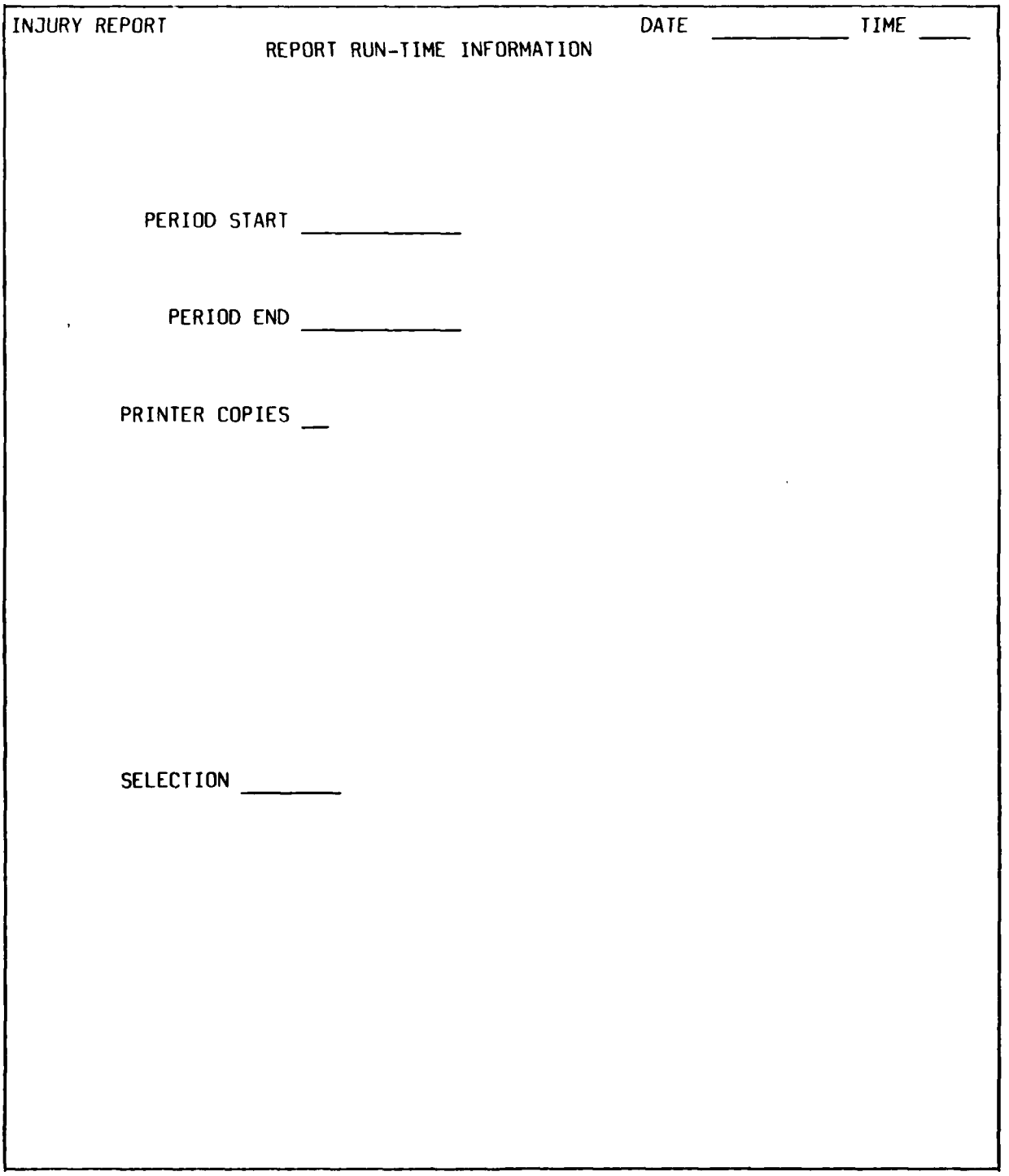
    1 - A & D REPORT
    2 - A & D RECAP
    3 - WARD NURSING REPORT
    4 - ALPHA ROSTER
    5 - VSI/SI/SC REPORT
    6 - DAILY ADMISSIONS BY DIAGNOSIS
    7 - ADMISSION NOTIFICATION LETTERS
    8 - PATIENT CHARGE ROSTER
    9 - DISPOSITION NOTIFICATION LETTERS
   10 - UCA BED DAYS RECAP

-------------------------------------------------------------------------
 N - ALL NIGHTLY REPORTS (1-9)          M - ALL MONTHLY REPORTS (10-11)
                                        P2 - DISPLAY NEXT PAGE

      ENTER REPORT NUMBER(S): _____________________
```

R/ADT REPORTS - SELECTION SCREEN
(Reports listed may vary)

UH007



R/ADT REPORTS - RUN-TIME INFORMATION SCREEN FOR THE INJURY REPORT

The Run-Time Information Screen displays different fields, or parameters, for each report. All screens contain a PRINTER COPIES field; many allow you to specify the report period, which is the period of time for which you want data. You must enter a date in any fields that ask you to specify the report period.

(1) PERIOD START. First day of the report period. **

(2) PERIOD END. Last day of the report period. **

(If you enter a PERIOD START of 01 JUN 85, and a PERIOD END date of 15 JUN 85, the report will include data on all patients with injury type cases who were in the MTF between these dates.

(3) PRINTER COPIES. Number of copies you want run. Entries you can make in this field are listed below. (Some reports cannot be displayed at a terminal; a message to that effect will appear at the top of this screen.)

- If you leave this field blank, the report will be displayed at your terminal instead of being printed.
- If you enter R, the last copy of the selected report will be displayed at your terminal.
- If you enter a number, that many copies of the report will be printed.
- If you enter R and a number (e.g., R3), the last copy of the selected report will be printed as many times as you indicate.

The SELECTION field on this screen operates in the same way as the ENTER SELECTION field on any other screen. You can enter all or part of the parameter label to return to that field and update it.

DATA CHART - RUN-TIME INFORMATION SCREEN

Part 2. A&D OUTPUTS (REPORTS)

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INTRODUCTION TO PART 2

This Part lists the A&D outputs alphabetically, and includes the following for each:

a. Definition - a brief description of the report or product, its purpose or function, frequency of production, distribution, and utilization. Also includes the criteria used to select the events or patient records to be included on the report.

All of the A&D reports are requested by the user through the A&D Report Selection function, unless otherwise indicated. The means of requesting A&D products will be specified in the relevant sections.

b. Format - the organization of the output's contents, and any header or trailer data it might include.

A&D reports begin with a standard header, unless otherwise indicated. This standard header includes the following data:

- Privacy Act Statement
- Run date and time
- MTF name
- Report page number
- Report name.

Many reports also display the time period for which the report is effective.

Most A&D reports do not display trailer data. Header and trailer data for products will be described in the relevant sections.

c. Content - a Data Chart describing each of the output's data elements.

Data elements that appear on many of the A&D outputs are described in detail in the Data Chart on the following page. Data Charts for the individual outputs will give detailed explanations of data elements that do not appear in this first Data Chart, and any other data elements that are not self-explanatory.

d. Example - a sample of each output. If the versions of a report produced for different military departments contain the same data elements, only one report example will be given.

(1) REGISTER NUMBER. 7-digit register number assigned to the inpatient episode during admission. The Air Force adds a 1-digit suffix to indicate newborns.

(2) PATIENT NAME. On most outputs, the patient name appears as it was entered in PTID--i.e., last name first, followed by comma, followed immediately by first name. First name can be followed by a space and a middle initial or middle name, and/or a space and a title. Last name can contain hyphens or apostrophe, but no other punctuation; first name and middle name can contain hyphens but no other punctuation.

(3) FMP. Patient's family member prefix. Indicates relationship of patient to sponsor. See Table 1012 for definitions of the codes.

(4) SSN. Social Security Number of patient's sponsor (or of patient if patient is the sponsor).

(5) SEX. Code for the patient's sex.

(6) DOB. Patient's date of birth.

(7) RACE. Code for the patient's race. See Table 1024.

(8) RELIGION. Code for the patient's religious preference. See Table 1000.

(9) MARITAL STATUS. Code for the patient's marital status.

(10) RANK. Code for the patient's rank. See Table 1006.

(11) PATIENT CATEGORY. Indicates the service affiliation and the authorization classification that authorizes the patient's care. Can be displayed as code only (e.g., N51), as the textual description (e.g., DEPN USN AD SPONSOR), or as both. See Table 1002.

(12) SOURCE OF ADMISSION. The source or type of the patient's admission (e.g., "DIR" for "direct," "TFR" for "transfer"). Can be displayed as code or textual description, or both. Also referred to as "type" of admission. See Table 2001.

(13) ADMISSION DATE AND TIME. The day, month, and year of the patient's admission, and the time of day, in military time.

(14) CLINICAL SERVICE. The clinical service to which the patient is assigned. Usually displayed as code. See Table 2005.

BASIC DATA CHART
Showing Data Common to AQCESS A&D Outputs

(15) WARD. The ID number of the ward to which the patient is assigned. Sometimes the name of the ward is displayed as well (e.g., pediatrics).

(16) ABSENT STATUS. Code for the patient's hospitalization status, e.g., BO (bed occupant), CL (on convalescent leave). Table 2002.

(17) TYPE CASE. Code indicating the type of medical case and its cause (e.g., disease, assault, battlefield injury, etc.). See Table 2004.

(18) CAUSE OF INJURY. The cause of the patient's injury, if the hospitalization is the result of injury. Can be displayed as code or textual description, or both. See Table 2009.

(19) PATIENT ADDRESS. Number, street, city, state, and zip code.

BASIC DATA CHART
Showing Data Common to AQCESS A&D Outputs

ADMISSION AND DISPOSITION (A&D) REPORT

a. Definition. The A&D Report describes all admission, disposition, change of absent status, and newborn activity in the MTF for a given day. The first part of the A&D Report consists of data on patients who had such an activity on that day, including current inpatients and patients with absent statuses whom the MTF is currently tracking. The second part of this report contains corrections to A&D activity data that appeared on previous reports. The A&D Report is produced daily, usually at midnight; a partial report can be run on demand. Its distribution is hospital-wide, and it is used to communicate information about the daily inpatient census.

b. Format. This report's header contains the standard data, plus the date and time when the period of the report ends.

The A&D Report consists of several major sections and subsections, depending on the type of admission and disposition activity being reported. Patient data is included within each section and subsection of the report, with two lines of data on each patient.

If a particular type of activity has not occurred during a specific period, that category will not appear on the report for that period. For example, on the Army A&D Report, if there were no direct admissions of active duty Army personnel on May 11, the section "Direct Admission to Hospital - Active Duty" would not appear on the May 11 Report.

A&D Report categories differ for each military department; possible categories making up the A&D Report for each service are listed below. Patient data included within the categories is described in the Data Chart for this report.

A&D Report Categories (Army)

I. Gains (Admissions)
- A. Direct Admission to Hospital
  1. Active Duty
  2. Dependents of Military Personnel
  3. Retired Military Personnel
  4. Others
- B. Direct Admission Absent Sick
- C. Transfer Admission
- D. Newborn

II. Changes of Status In
- A. From Leave
- B. From Subsisting Out
- C. From AWOL (Less than 11 Days)
- D. From Absent Sick in Non-Military MTF
- E. From TDY/SDY

A&D Report Categories (Army) (continued)

II. Changes of Status In (continued)
- F. From Supplemental Care
- G. From Cooperative Care
- H. From Medical Hold
- I. From Absent in Custody of Military Authority
- J. From Other Authorized Absence

III. Losses (Dispositions)
- A. Returned to Duty
- B. Separated from Service
- C. Retired - Length of Service
- D. Retired - PDRL
- E. Retired - TDRL
- F. AWOL over 10 Days
- G. Discharged from Hospital
  1. Dependents of Military Personnel
  2. Retired Military Personnel
  3. Newborn
  4. Others
- H. Died
  1. Newborn
  2. Others
- I. Transferred
  1. Newborn
  2. Others

IV. Changes to Status Out
- A. To Leave
- B. To Subsisting Out
- C. To AWOL
- D. To Absent Sick in Non-Military Hospital
- E. To TDY/SDY
- F. To PCS Home or VA Hospital
- G. To Supplemental Care
- H. To Cooperative Care
- I. To Medical Hold
- J. To Absent in Custody of Military Authority
- K. To Other Authorized Absence

V. Other Transactions
- A. Interward Transfers
- B. Carded for Record Only
- C. Passes in Excess of 24 Hours
  1. To Pass
  2. From Pass
- D. From Newborn to Pay Patient

VI. Corrections to Prior A&D Reports
- A. Corrections to Gains

A&D Report Categories (Army) (continued)

VI. Corrections to Prior A&D Reports (cont'd.)
- B. Corrections for Change of Status In
  1. From Leave
  2. From Subsisting Out
  3. From AWOL (Less than 11 Days)
  4. From Absent Sick in Non-Military MTF
  5. From TDY/SDY
  6. From Supplemental Care
  7. From Cooperative Care
  8. From Medical Hold
  9. From Absent in Custody of Military Authority
  10. From Other Authorized Absence
  11. From Pass
- C. Corrections for Losses
- D. Corrections for Change of Status Out
  1. To Leave
  2. To Subsisting Out
  3. To AWOL
  4. To TDY/SDY
  5. To PCS Home or VA Hospital
  6. To Supplemental Care
  7. To Cooperative Care
  8. To Medical Hold
  9. To Absent in Custody of Military Authority
  10. To Other Authorized Absence
  11. To Pass
- E. Corrections for Interward Transfers
- F. Admissions Cancelled for Previous Date
- G. Dispositions Cancelled for Previous Date
- H. Changes from Retained/Pay Status to Newborn
- I. Other Corrections

A&D Report Categories (Air Force)

I. Gains (Admissions)
- A. Admissions - Duty to Hospital
- B. Admissions - Duty to Quarters
- C. Admissions - Duty to Non-Military Hospital
- D. Admissions - Transfers-In
- E. Admissions - Other

II. Changes of Status In
- A. Change of Status - In From Leave
- B. Change of Status - In From AWOL
- C. Change of Status - In From Quarters
- D. Change of Status - In From Subsisting Elsewhere

A&D Report Categories (Air Force) (continued)

II. Changes of Status In (cont'd.)
- E. Change of Status - In From Non-Military Hospital
- F. Change of Status - In Newborn Remaining After Discharge of Mother
- G. Change of Status - In From Other Absent Status
- H. Change of Status - In From Medical TDY

III. Losses (Dispositions)
- A. Disposition - Hospital to Duty
- B. Disposition - Quarters to Duty
- C. Disposition - Transfer Out
- D. Disposition - Evacuated to US
- E. Disposition - Discharge from Service, Non-Medical
- F. Disposition - Separation or Retirement, Physical Disability
- G. Disposition - Death
- H. Disposition - Other
- I. Disposition - Non-Military Hospital to Duty

IV. Changes to Status Out
- A. Change of Status - Out to Leave
- B. Change of Status - Out to AWOL
- C. Change of Status - Out to PCS Home
- D. Change of Status - Out to VA Hospital
- E. Change of Status - Out to Subsisting Elsewhere
- F. Change of Status - Out to Medical TDY
- G. Change of Status - Out to Other Absent Status

V. Interward Transfers

VI. Newborn Activity
- A. Newborn - Births
- B. Newborn - Deaths
- C. Newborn - Departures

VII. Carded for Record Only

VIII. Emergency Service Death

IX. Auto Corrections for Previous A&D Reports
- A. Corrections for Gains
- B. Corrections for Change of Status In
- C. Corrections for Losses
- D. Corrections from Change of Status Out
- E. Corrections for Interward Transfers
- F. Admissions Cancelled for a Previous Admission Date
- G. Dispositions Cancelled from Previous Disposition Date
- H. Changes from Retained/Pay Status to Newborn
- I. Manual Text Corrections

A&D Report Categories (Navy)

I. Gains (Admissions)
   A. Direct Admissions - Other
   B. Direct Admissions - Active Duty U.S. Uniformed Services
   C. Transfer from Other Military Facility - Other
   D. Transfer from Other Facility - Active Duty U.S. Uniformed Services
   E. Transfer from Other Medical Facility - Other
   F. Transfer from Other Facility - Active Duty U.S. Uniformed Services

II. Changes of Status In
   A. Status In - Absent in Custody of Civilian Authorities
   B. Status In - Absent in Custody of Military Authorities
   C. Status In - AWOL
   D. Status In - Absent Other Treatment Facility
   E. Status In - On Cooperative Care
   F. Status In - Convalescent Leave
   G. Status In - Ordinary Leave
   H. Status In - Supplemental Care
   I. Status In - Subsisting Elsewhere
   J. Status In - TDY

III. Changes of Status Out
   A. Status Out - From Custody of Civilian Authorities
   B. Status Out - From Custody of Military Authorities
   C. Status Out - From AWOL
   D. Status Out - From Other Treatment Facility
   E. Status Out - From Cooperative Care
   F. Status Out - From Convalescent Leave
   G. Status Out - From Ordinary Leave
   H. Status Out - From Supplemental Care
   I. Status Out - From Subsisting Elsewhere
   J. Status Out - From TDY

IV. Ward Transfers

V. Losses (Dispositions)
   A. Transferred Out - Other
   B. Transferred Out - ACDU USUS
   C. Disposition to Home
   D. Disposition to Duty - ACDU USUS
   E. Disposition to Convalescent Leave
   F. Disposition Death - Other
   G. Disposition Death - U.S. Uniformed Services
   H. Status Out - Medical Holding Company

A&D Report Categories (Navy) (continued)

VI. Newborn Activity
- A. Livebirth
- B. Newborn Direct with Mother
- C. Newborn Transferred in with Mother
- D. Newborn Retained
- E. Newborn Disposition to Home
- F. Transferred Out - Newborns
- G. Disposition Death - Newborns

VII. Corrections for Previous A&D Reports
- A. Corrections for Gains
- B. Corrections for Losses
- C. Corrections for Changes of Status In
- D. Corrections for Changes of Status Out
- E. Corrections for Ward Transfers
- F. Corrections for Admission Cancellations
- G. Corrections for Disposition Cancellations
- H. Changes from Retained/Pay Status to Newborn
- I. Manual Text Corrections

c. Content. The A&D Report displays the following data for each patient included in each reporting category:

(1) REG NO. Register number of the patient.

(2) PATIENT NAME.

(3) FMP. Patient's family member prefix. Table 1012.

(4) SPONSOR SSN. SSN.

(5) RANK of the patient's sponsor (or of the patient if the patient is the sponsor). Table 1006.

(6) PNT-CAT. Code for the patient's patient category. Table 1002.

(7) DUTY ADDRESS/RELATIONSHIP. Duty address of patient or patient's sponsor. This field displays the description of the patient category if the patient not active duty.

(8) TYPE CASE. Table 2004.

(9) TIME of admission.

(10) WARD. The ward to which the patient is assigned. If the patient has an "out" absent status, this field shows the absent status, preceded by an asterisk.

(11) MTF DAYS. Number of days the patient has spent at the MTF since date of admission. This field is used by the Navy only.

(13) FS. Flying status. Table 1014.

DATA CHART - ADMISSION AND DISPOSITION REPORT

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE 31 AUG 1985 1819

TEST AIRFORCE MTF PAGE 1

PERIOD ENDING 2400 HOURS 30 AUG 1985 * 85242 *

* * * * * ADMISSION AND DISPOSITION REPORT * * * * *

REG NO / FMP SPONSOR SSN	PATIENT NAME / RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE CASE	TIME	WARD / FS
********** ADMISSIONS - DUTY TO HOSPITAL **********						
*0002003	REYNOLDS,DAVID			DIS	1300	5T
20 209-19-2872	AMN	F12	20981			
0002007	MICCIOLI,BRADLEY			DIS	1200	4S
20 209-87-3764	CPT	F11	30198			2B
0002008	LAWRENCE,DAVID			DIS	1430	4S
20 098-29-8172	2LT	F11	24398			2S
*0002009	SZABO,CHRISTOPHER			DIS	1200	4S
20 309-82-0912	AB	F11	24812			3L
********** ADMISSION - TRANSFERS IN **********						
TRANSFERS-IN FROM (1263) USAF HOSP, HOMESTEAD AFB, FL 33039						
*0002005	WILLINGHAM,STEVEN			DIS	1030	1X
20 308-29-8298	AB	F11	22012			1U
********** ADMISSION - OTHER **********						
0002002	BRYAN,MARY		DEPN AD USAF	DIS	0930	4S
30 209-18-2987	CIV	F41				
0002004	JONES,BETH		DEPN AD USAF	DIS	1000	5U
02 098-29-2871	CIV	F41				
0002006	EVERETT,NANCY		DEPN AD USAF	DIS	0900	4E
30 309-88-2987	CIV	F41				
********** CHANGE OF STATUS - IN FROM NON-MILITARY HOSPITAL **********						
0000800	TESTER,ABE			DIS	1200	4S
20 888-99-9888	CPT	F11	99999			
********** DISPOSITION - HOSPITAL TO DUTY **********						
0002011	RIORDAN,JEFF			DIS	1200	*BO
20 209-89-3838	2LT	F11	20012		1U	4S
********** CHANGE OF STATUS - OUT TO OTHER ABSENT STATUS **********						
0002010	CROWN,GARY			DIS	0900	*SC
20 209-12-1983	2LT	F11	20989		5A	4S

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE 31 AUG 1985 1819

TEST AIRFORCE MTF PAGE 2

PERIOD ENDING 2400 HOURS 30 AUG 1985 * 85242 *

* * * * * ADMISSION AND DISPOSITION REPORT * * * * *

REG NO / FMP SPONSOR SSN	PATIENT NAME / RANK	DUTY ADDRESS/ RELATIONSHIP / PNT-CAT	TYPE CASE	TIME / FS	WARD
0002010	CROWN,GARY		DIS	1200	4S
20 209-12-1983	2LT	20989 / F11			5A
0002011	RIORDAN,JEFF		DIS	1200	4S
20 209-89-3838	2LT	20012 / F11			1U

********** AUTO CORRECTIONS FOR PREVIOUS A&D REPORTS **********

********** CORRECTIONS FOR ADMISSIONS **********

CHANGES TO REPORT OF 20 AUG 1985

ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE

CHANGES TO REPORT OF 25 AUG 1985

ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE

A&D REPORT (AIR FORCE)

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE 31 AUG 1985 1656

TEST ARMY MTF PAGE 1

PERIOD ENDING 2400 HOURS 30 AUG 1985 * 65242 *

*** * * * * ADMISSION AND DISPOSITION REPORT * * * * ***

REG NO / FMP SPONSOR SSN	PATIENT NAME / RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE CASE	TIME	WARD FS
GAINS (ADMISSIONS)						
DIRECT ADMISSION TO HOSPITAL						
ACTIVE DUTY						
0003438 20 249-34-8789	RIVERTON,DALLAS MSG	A12	WALTER REED AMC WASHINGTON DC 20013	DIS	1200	4E N
TRANSFER ADMISSION						
TRANSFERS-IN FROM (0311) USACH, BERLIN, GE						
0003443 20 398-47-3827	EVERETT,SAM MSG	A12	SILVER SPRING MD 20910	DIS	1200	4E N
LOSSES (DISPOSITIONS)						
DISCHARGED FROM HOSPITAL						
DEPENDENTS OF MILITARY PERSONNEL						
0003444 02 292-38-9878	JOHNSTON,DAVID CIV	A51	DEPN AD US ARMY SPONSOR	DIS	1100	*BO 3N
0003441 30 389-09-1717	WATSON,LISA CIV	A51	DEPN AD US ARMY SPONSOR	DIS	1200	*BO 6S
TRANSFERRED						
OTHERS						
TRANSFERS-OUT TO (N003) NH BETHESDA						
0003436 20 342-91-3822	YOUNG,ALAN 1LT	A11	FT MEADE 24102	DIS	0930 N	*BO 4E
CORRECTIONS TO PRIOR A&D REPORTS						
CORRECTIONS TO GAINS						
CHANGES TO REPORT OF 27 JUL 1985						
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE						
0003437 20 241-98-4738	BLACKWELL,JAMES MAJ	A11	PENTAGON WASHINGTON DC 20410	DIS	0900 N	4E

* * * * * ADMISSION AND DISPOSITION REPORT * * * * *

REG NO / FMP SPONSOR SSN	PATIENT NAME / RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE CASE	TIME FS	WARD
********** CORRECTIONS TO PRIOR A&D REPORTS **********						
********** CORRECTIONS TO GAINS **********						
CHANGES TO REPORT OF 19 AUG 1985						
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE						
0003444 02	JOHNSTON,DAVID 292-38-9878	CIV	DEPN AD US ARMY SPONSOR	DIS	1200	3N
CHANGES TO REPORT OF 20 AUG 1985						
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE						
0003441 30	WATSON,LISA 389-09-1717	CIV A51	DEPN AD US ARMY SPONSOR	DIS	0930	6S
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE						
0003436 20	YOUNG,ALAN 342-91-3822	1LT A11	FT MEADE 24102	DIS N	1200	4E
CHANGES TO REPORT OF 26 AUG 1985						
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE						
0003442 01	WATSON,MELISSA 389-09-1717	CIV A51	DEPN AD US ARMY SPONSOR	DIS	0101	6W
CHANGES TO REPORT OF 27 AUG 1985						
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE						
0003439 30	MORLEY,ANDREA 349-83-9020	CIV A51	DEPN AD US ARMY SPONSOR	DIS	0900	6S
CHANGES TO REPORT OF 28 AUG 1985						
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE						
0003440 01	MORLEY,ANDREW 349-83-9020	CIV N51	DEPN USN AD SPONSOR	DIS	0200	6W
********** CORRECTIONS FOR CHANGE OF STATUS OUT **********						
********** TO COOPERATIVE CARE **********						
CHANGES TO REPORT OF 08 AUG 1985						
ABSENT STATUS CHANGE TO STATUS OUT ON OTHER THAN EFFECTIVE DATE						
0003437 20	BLACKWELL,JAMES 241-98-4738	MAJ A11	PENTAGON WASHINGTON DC 20410	DIS N	1200	*CC 4E

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE 31 AUG 1985 1813

TEST NAVY MTF PAGE 1

PERIOD ENDING 2400 HOURS 30 AUG 1985 * 85242 *

* * * * * ADMISSION AND DISPOSITION REPORT * * * * *

REG NO / FMP SPONSOR SSN	PATIENT NAME / RANK	PNT-CAT	DUTY ADDRESS / RELATIONSHIP	TYPE MTF	CASE DAYS	TIME FS	WARD
********** DIRECT ADMISSIONS - OTHER **********							
0006483	BELLAMY,LAURA		DEPN USN ACTIVE DUTY	DIS	0	0830	4S
30 290-12-1921	CIV	N41					
0006482	BERTRAM,JOHNNY		DEPN USN ACTIVE DUTY	DIS	0	0900	5T
02 392-89-1823	CIV	N41					
0006479	FRANKLIN,SANDRA		DEPN USN ACTIVE DUTY	DIS	0	0500	4E
30 342-81-9384	CIV	N41					
0006478	KUSHNIK,HARRY		DEPN USN ACTIVE DUTY	DIS	0	1000	4S
55 248-18-2983	CIV	N41					
0006484	ROGERS,STEVEN		DEPN USN ACTIVE DUTY	DIS	0	1200	5S
02 291-82-1982	CIV	N41					
********** DIRECT ADMISSIONS - ACTIVE DUTY U.S. UNIFORMED SERVICES **********							
0006477	JOHNSON,SAM		NAVAL TRAINING CENTER	DIS	0	0900	4S
20 241-92-8342	CW3	N11	ORLANDO FL 32801			N	
0006487	WILLIAMS,CARL			DIS	0	1200	*CC
20 129-23-1829	CPT	N11					
********** STATUS IN - CONVALESCENT LEAVE **********							
0006455	MYERS,PETER		USS ENTERPRISE	INJ	23	1100	5T
20 756-56-7654	CPT	N11	EUSTIS FL 32726				
0006480	WALKER,LARRY			DIS	10	1200	4S
20 231-83-0293	DN	N11	23121			N	
********** STATUS OUT - FROM COOPERATIVE CARE **********							
0006487	WILLIAMS,CARL			DIS	0	1200	*CC
20 129-23-1829	CPT	N11					
********** STATUS OUT - FROM CONVALESCENT LEAVE **********							
0006480	WALKER,LARRY			DIS	10	1130	*BO
20 231-83-0293	DN	N11	23121			N	4S
********** WARD TRANSFERS **********							
0006483	BELLAMY,LAURA		DEPN USN ACTIVE DUTY	DIS	0	0845	4E
30 290-12-1921	CIV	N41					4S
0006482	BERTRAM,JOHNNY		DEPN USN ACTIVE DUTY	DIS	0	0915	5U
02 392-89-1823	CIV	N41					5T

* * * * * ADMISSION AND DISPOSITION REPORT * * * * *

REG NO / FMP SPONSOR SSN	PATIENT NAME / RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE MTF	CASE DAYS	TIME	WARD FS
**********TRANSFERRED OUT - ACDU USUS**********							
TRANSFERS-OUT TO (N015) NAVHOSP GROTON, NEW LONDON, CT							
0006463	WHITE,BARRY		111 WWW	DIS		0900	*BO
20 222-22-2222	CPT	N11	ALEXANDRIA VA 22312	14			4E
**********DISPOSITION TO DUTY - ACDU USUS**********							
0006469	JONES,BOB		NAVY TRAINING CENTER	DIS		1030	*BO
20 888-33-3121	CDR	N11	ORLANDO FL 32802	9			4S
**********LIVEBIRTH**********							
0006481	FRANKLIN,MATTHEW		DEPN USN ACTIVE DUTY	DIS		0945	23E
01 342-81-9384	CIV	N41		0			
**********CORRECTIONS FOR GAINS**********							
CHANGES TO REPORT OF 11 JUL 1985							
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE							
0006488	SANTOS,MANUEL			DIS		1400	4S
20 238-19-2828	ENS	N11		50			
CHANGES TO REPORT OF 20 JUL 1985							
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE							
0006486	HARVEY,BILL		DEPN USN ACTIVE DUTY	DIS		1200	4S
30 231-92-8317	CIV	N41		41			
CHANGES TO REPORT OF 24 JUL 1985							
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE							
0006490	LINDEMAN,ERIC			DIS		0900	4S
20 342-98-4747	ENS	N11		37	N		
CHANGES TO REPORT OF 25 JUL 1985							
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE							
0006489	LUCAS,WILLIAM			DIS		1200	4S
20 349-58-2717	CPT	N11		36	N		
CHANGES TO REPORT OF 20 AUG 1985							
ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE							
0006480	WALKER,LARRY			DIS		1200	4S
20 231-83-0293	DN	N11	23121	10	N		

* * * * * ADMISSION AND DISPOSITION REPORT * * * * *

REG NO / FMP	PATIENT NAME / SPONSOR	SSN	RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE MTF	CASE DAYS	TIME FS	WARD
0006485	GEORGE,STEPHANIE				DEPN USN ACTIVE DUTY	DIS	1200		4S
30	293-81-2828	CIV	N41			2			

********** CORRECTIONS FOR GAINS **********

CHANGES TO REPORT OF 28 AUG 1985

ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE

REG NO / FMP	PATIENT NAME / SPONSOR	SSN	RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE MTF	CASE DAYS	TIME FS	WARD
0006485	GEORGE,STEPHANIE				DEPN USN ACTIVE DUTY	DIS	1200		4S
30	293-81-2828	CIV	N41			2			

********** CORRECTION FOR LOSSES **********

CHANGES TO REPORT OF 29 AUG 1985

DISPOSITION ENTERED ON OTHER THAN CURRENT DATE

REG NO / FMP	PATIENT NAME / SPONSOR	SSN	RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE MTF	CASE DAYS	TIME FS	WARD
0006460	TEST,BABY				DEPN USN ACTIVE DUTY	DIS	1200		*BO
01	222-22-2222	CIV	N41			21			4E

********** CORRECTIONS FOR CHANGES OF STATUS OUT **********

CHANGES TO REPORT OF 21 JUL 1985

ABSENT STATUS CHANGE TO STATUS OUT ON OTHER THAN EFFECTIVE DATE

REG NO / FMP	PATIENT NAME / SPONSOR	SSN	RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE MTF	CASE DAYS	TIME FS	WARD
0006488	SANTOS,MANUEL					DIS	0900		*CL
20	238-19-2828	ENS	N11			50			4S

CHANGES TO REPORT OF 02 AUG 1985

ABSENT STATUS CHANGE TO STATUS OUT ON OTHER THAN EFFECTIVE DATE

REG NO / FMP	PATIENT NAME / SPONSOR	SSN	RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE MTF	CASE DAYS	TIME FS	WARD
0006490	LINDEMAN,ERIC					DIS	1500		*AM
20	342-98-4747	ENS	N11			37	N		4S

CHANGES TO REPORT OF 10 AUG 1985

ABSENT STATUS CHANGE TO STATUS OUT ON OTHER THAN EFFECTIVE DATE

REG NO / FMP	PATIENT NAME / SPONSOR	SSN	RANK	PNT-CAT	DUTY ADDRESS/ RELATIONSHIP	TYPE MTF	CASE DAYS	TIME FS	WARD
0006489	LUCAS,WILLIAM					DIS	1600		*SE
20	349-58-2717	CPT	N11			36	N		4S

A&D REPORT (NAVY)

A&D RECAP/PATIENT STRENGTH REPORT

a. Definition. This report is called the A&D Recap by the Army, and the Patient Strength Report by the Navy and Air Force. It summarizes A&D data by patient category and absent status, and includes all inpatients and patients on "out" absent statuses on the day of the report. This report is usually printed daily. It is distributed at the hospital administrative and nursing supervisory level, and is used to monitor bed demand and the hospital census.

b. Format. In addition to the standard data, the header for this report displays the date on which the period of the report ends. The body of the report is arranged in table form, with the patient category given on the left.

c. Content. The body of the A&D Recap and Patient Strength Reports contains the data described in the Data Chart below.

(1) PNT CAT. Description of the patient's patient category. Table 1002.

(2) PREV REPORT. The number of patients with this patient category present in the MTF, minus gains, plus losses. On A&D Recap only (Army).

(3) GAINS. The number of gains (admissions) in this patient category since the previous report.

(4) LOSSES. The number of losses (dispositions) in this patient category since the previous report.

(5) PRES REPORT. The number of patients with this patient category currently in the hospital.

Items (6) through (8) show the number of current inpatients who have the specified patient category and the absent statuses listed:

(6) SUB ELSE. Subsisting elsewhere.

(7) ABSENT SICK.

(8) QTRS. In quarters. Air Force and Navy only.

(9) OTHER ABSENT.

(10) TOTAL ABSENT. The number of current inpatients with this patient category who have absent statuses other than "BO" (bed occupied).

DATA CHART - A&D RECAP/PATIENT STRENGTH REPORT

(11) ON PASS. The number of inpatients with this patient category who are currently on pass. Army only.

(12) NEWBORN. The number of current inpatients with this patient category who are newborns.

(13) BEDS TOTAL. The number of inpatients who are currently occupying beds in the MTF.

(14) TOTAL. The end of the report gives totals for data items (2) through (13).

DATA CHART - A&D RECAP/PATIENT STRENGTH REPORT

TEST ARMY MTF

RUN DATE: 05 SEP 1985

PERSONAL DATA - PRIVACY ACT 1974

PAGE: 1

ADMISSION AND DISPOSITION RECAPITULATION

PERIOD ENDING 2400 HOURS 30 AUG 1985

PNT CATEGORY	PREV RPT	GAINS	LOSSES	PRES RPT	SUB ELSE	ABS SICK	OTH ABS	TOTAL ABS	ON PASS	NEW BORN	BEDS TOTAL
USA AD OFFICER	2	0	1	1	0	0	1	1	0	0	0
USA AD ENLISTED	0	2	0	2	0	0	0	0	0	0	2
DEPN AD US ARMY SPONSOR	4	0	3	1	0	0	0	0	0	0	1
DEPN USN AD SPONSOR	1	0	0	1	0	0	0	0	0	1	1
TOTAL:	7	2	4	5	0	0	1	1	0	1	4

A&D RECAP REPORT (ARMY)

TEST AIRFORCE MTF

RUN DATE: 16 SEP 1985
PAGE: 1

PERSONAL DATA - PRIVACY ACT 1974

PATIENT STRENGTH REPORT

PERIOD ENDING 2400 HOURS 30 AUG 1985

PNT CATEGORY	GAINS	LOSSES	PRES RPT	SUB ELSE	ABS SICK	QTRS	OTH ABS	TOT ABS	NEW BORN	BEDS TOTAL
ACT-DUTY USAF	4	1	7	0	0	0	1	1	0	6
AF NAT GUARD	1	0	1	0	0	0	0	0	0	1
FEMALE FORMER MILITARY USAF	0	0	1	0	0	0	0	0	0	1
DEPN AD USAF	3	0	4	0	0	0	0	0	0	4
NEWBORN OF FEMALE FORMER USAF	0	0	1	0	0	0	0	0	1	1
OTHERS	0	0	1	0	0	0	0	0	1	1
TOTAL:	8	1	15	0	0	0	1	1	2	14

PATIENT STRENGTH REPORT (AIR FORCE)

UH007

TEST NAVY MTF

RUN DATE: 05 SEP 1985

PERSONAL DATA - PRIVACY ACT 1974

PAGE: 1

PATIENT STRENGTH REPORT

PERIOD ENDING 2400 HOURS 30 AUG 1985

PNT CATEGORY	GAINS	LOSSES	PRES RPT	SUB ELSE	ABS SICK	QTRS	OTH ABS	TOT ABS	NEW BORN	BEDS TOTAL
USAR AD DEPN	0	0	1	0	0	0	0	0	0	1
USN ACTIVE DUTY	2	1	9	1	0	0	3	4	0	5
DEPN USN ACTIVE DUTY	6	0	9	0	0	0	0	0	1	9
TOTAL:	8	1	19	1	0	0	3	4	1	15

PATIENT STRENGTH REPORT (NAVY)

ADMISSION COVER SHEET or ADMISSION FORM

a. Definition. This product contains patient identification and admission information on an individual patient. It is referred to as the Admission Cover Sheet by the Army, and as the Admission Form by the Navy. (The Air Force does not use this product.)

The Admission Cover Sheet or Form is produced automatically when a patient is admitted, and can be requested by the user from the Admission or Transfer function (Inpatient Products segment). It is used as the patient chart, and its distribution is determined by the MTF command.

b. Format. The header for this product varies for each military department. The Army Cover Sheet includes a header containing the report title and a reference to AR 40 and the Office of the Surgeon General. The Navy Admission Form header consists of the number and title of the form.

The body of both Admission Forms is arranged in a grid format, with one or more data elements to each block of the grid.

c. Content. The content of this product also varies for each military department. A separate Data Chart is shown for the Army and the Navy forms.

(1) REGISTER NUMBER of patient.

(2) NAME of patient (last name, first, middle initial).

(3) GRADE. Patient's pay grade. (Grade associated with patient's rank.)

ADMISSION REMARKS.

(4) SEX of patient.

(5) AGE of patient.

(6) RACE. Table 1024.

(7) RELIGION. Table 1000.

(8) LENGTH OF SVC. Length of military service, if patient is a sponsor. Table 2014.

(9) ETS. Date when patient's term of service will expire. Can show INDEF if that date is indefinite.

DATA CHART - ADMISSION COVER SHEET (ARMY)

(10) PREVIOUS ADMISSION. "YES" in this field indicates that this patient has previously been admitted to this MTF.

(11) FMP. Patient's family member prefix. Indicates relationship of patient to sponsor. Table 1012.

(12) SSN.

(13) ORGANIZATION authorizing patient's admission.

(14) WARD.

(15) FLYING STATUS. Patient's flying status or aviation status code. Table 1014.

(16) RATING/DSG. Patient's aeronautical rating. Table 1009.

(17) DEPT/BEN. For active duty, this field shows the military department. For others, it gives the patient category. Table 1002.

(18) BRANCH/CORPS. For Army officers, Army branch of service. For Army enlisted, this field will be blank. Table 1023.

(19) UIC/ZIP. Unit Identification Code or zip code of patient's sponsor, or of patient if patient is a sponsor.

(20) TYPE CASE. Table 2004.

(21) SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION. Source of the patient's admission or authority for admission. Source of admission from 2001; authority for admission from Table 1002.

(22) HOUR OF ADMISSION.

(23) CLINIC SERVICE. Short description. Table 2005.

(24) NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE. Name of emergency addressee or next of kin, and his/her relationship to the patient. See Table 2012 for relationship.

(25) TYPE DISPOSITION. Code indicating patient's disposition status at the end of hospitalization. Will be blank. Table 2007.

(26) DATE OF DISPOSITION.

ADMITTING OFFICER.

DATA CHART - ADMISSION COVER SHEET (ARMY)

(27) ADDRESS OF EMERGENCY ADDRESSEE (INCLUDE ZIP CODE). Also: TELEPHONE NO. of emergency addressee.

(28) DATE OF THIS ADMISSION.

(29) NAME AND LOCATION OF MEDICAL TREATMENT FACILITY.

(30) DATE OF INITIAL ADMISSION. If this patient is a transfer-in, the date when the patient was admitted to the MTF he or she transferred from.

(31) SELECTED ADMINISTRATIVE DATA. Free text.

(32) UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED.

(33) CAUSE OF INJURY. Description. Table 2009.

The remaining fields on the Cover Sheet are not used at admission. See the description of the Inpatient Treatment Record Cover Sheet in Appendix C.

DATA CHART - ADMISSION COVER SHEET (ARMY)

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40 - 400; the proponent agency is the Office of The Surgeon General.

1. REGISTER NUMBER	2. NAME (Last, First, MI)					3. GRADE	ADMISSION REMARKS
0000085	JOHNSON,RICHARD					1LT	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M	44	5	CAT	02	01 JAN 1990	NO	
11. FMP	12. SSN		13. ORGANIZATION			14. WARD	
20	732931823					5E	
15. FLYING STATUS	16. RATING/DSG	17. DEPT/BEN	18. BRANCH/CORPS.	19. DIC/ZIP		20. TYPE CASE	
76	R	ARMY	AG	13243		DIS	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOUR OF ADMISSION	23 CLINIC SERVICE	
DIR DIRECT ADMISSION AR 40-3 PARA 4-1	0945	INT MED	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION	
JOHNSON,PAT/WIFE			ADMITTING OFFICER
27. ADDRESS OF EMERGENCY ADDRESSEE (INCLUDE ZIP CODE)	TELEPHONE NO.	28. DATE OF THIS ADMISSION	SEATON
SILVER SPRING MD 20910		24 MAY 1985	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		30. DATE OF INITIAL ADMISSION	
WALTER REED AMC			

31. SELECTED ADMINISTRATIVE DATA

Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSIS/OPERATIONS AND SPECIAL PROCEDURES

☐ Check If Continued on Reverse

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORD OFFICER

ADMISSION COVER SHEET (ARMY)

UH007

(1) PATIENT'S NAME. In format: Last, first, middle.

(2) TIME ADMITTED to this MTF.

(3) ADMISSION DATE.

(4) REPORTING MEDICAL TREATMENT FACILITY (UIC). Unit Identification Code for this MTF.

(5) LOC CODE. AQCESS is designed to operate at fixed facilities. This data element will be blank except for field activities.

(6) REGISTER NUMBER of this patient.

(7) DUTY STATION. Address of the patient's duty station. Active duty Navy and Marine Corps only. Also: SHIP STATION CODE. Unit Identification Code of patient's ship assignment. Active duty Navy or Marine Corps only.

(8) FAMILY PREFIX. Patient's family member prefix. Table 1012.

(9) SOCIAL SECURITY NUMBER of patient's sponsor (or of patient, if patient is the sponsor).

(10) SEX CODE. Patient's sex.

(11) RACE. Description and code of the patient's race.

(12) RELIGION. Table 1000.

(13) HOME ADDRESS or DUTY STATION. This field should contain home address if patient is not active duty; duty address if patient is active U.S. Army or Air Force.

(14) MARITAL STATUS.

(15) BIRTH DATE of patient.

(16) LENGTH OF SERVICE of patient. Enter number of years and months, in the format YYMM (0000 through 5511), e.g., 0205 = 2 years and 5 months.

(17) PAY GRADE CODE.

(18) DES/MOS/NEC. Patient's military occupation code.

DATA CHART - ADMISSION FORM (NAVY)

(19) RECORDS RECEIVED. In this field the records that this MTF has received on the patient can be indicated. These records are: HR (health record), DR (dental record), SR (service record), PR (pay record), ORD (orders), and PE (personel effects).

(20) DEPENDENT'S ID CARD NUMBER and EXP DATE. Patient's 10-character military identification card number.

(21) PATIENT CATEGORY. The description and code of the patient's patient category. Table 1002.

(22) TYPE OF ADMISSION. For example, live birth in hospital, transfer-in, or direct admission. Table 2001.

(23) MIL TH OP CODE. Code for patient's military theater of operations.

(24) NEXT OF KIN SPONSOR. Name, address, relationship and phone no. of patient's next of kin.

(25) CLINIC SERVICE. Description and code of patient's clinical service assignment.

(26) NOTIFY IN CASE OF EMERGENCY. The person to notify, other than next of kin, in case of an emergency involving this patient. Give name, address, relationship and phone number.

REMARKS regarding the admission.

(27) ADMISSION DIAGNOSIS. Description and code of the diagnosis made on this patient at time of admission. Include body part, anatomic site if applicable. Table 9001.

(28) MEDICAL TREATMENT FACILITY TRANSFERRED FROM. Name and code of MTF transferred from, if any.

(29) ORIGINAL ADMISSION DATE. Date of admission to the MTF transferred from, if any.

(30) CIRCUMSTANCES OF ACCIDENT, VIOLENCE, POISONING. (1) Indicate if event occurred to an active duty U.S. Uniformed Services member while on duty. Also: CAUSE CODE. Code for cause of injury, if any. Table 2009. (2) Record briefly the circumstances of the injury (what when, where, how).

(31) DISPOSITION DATE. Day, month, and year of patient's disposition.

DATA CHART - ADMISSION FORM (NAVY)

(32) DISPOSITION TO. Description and code for the type of this patient's disposition. Table 2007.

(33) PATIENT'S NAME. Last, first, middle.

(34) GRADE/RATE. Patient's pay grade.

(35) WARD. Ward to which the patient was assigned at admission.

(36) REPORTING MEDICAL TREATMENT FACILITY. Description and code of this MTF. Table 1005.

DATA CHART - ADMISSION FORM (NAVY)

NHEETH (16)6190/28 (FRONT)
LSN 0198-LL L00-4068

INPATIENT ADMISSION/DISPOSITION RECORD

1 PATIENT'S NAME (LAST, FIRST, MIDDLE)	2 TIME ADMITTED	3 ADMISSION DATE	4 REPORTING MEDICAL TREATMENT FACILITY (UIC)	5 LOC CODE	6 REGISTER NUMBER
THOMAS,LARRY	1015	19JUN85			0000175

7 DUTY STATION (ACDU NAVY & MARINE CORPS ONLY)	8 FAMIL PREFIX	9 SOCIAL SECURITY NUMBER	10 SEX CODE	11 RACE	12 RELIGION
SHIP STATION CODE	30	263-21-8797	M	NEGR01 CODE N	

13 a HOME ADDRESS (OTHER THAN ACTIVE DUTY OR b DUTY STATION (ACDU U.S. ARMY AND AIR FORCE ONLY)	14 MARITAL STATUS	15 BIRTH DATE	16 LENGTH OF SERVICE	17 PAY GRADE CODE	18 DES MOS NEC	19 RECORDS RECEIVED HP OR SR PR ORD PE
4669 SEQUOYAH RD WHEATON MD 20915	M	03JUN58				

20 DEPENDENTS ID CARD NUMBER / EXP DATE	21 PATIENT CATEGORY	CODE	22 TYPE OF ADMISSION	CODE	23 MIL TH OP CODE
	DEPN USN ACTIVE DUTY	N41		DIR	

24 NEXT OF KIN SPONSOR (GIVE NAME, ADDRESS, RELATIONSHIP AND PHONE NO.)	25 CLINIC SERVICE	CODE	26 NOTIFY IN CASE OF EMERGENCY IF OTHER THAN NEXT OF KIN (GIVE NAME, ADDRESS, RELATIONSHIP AND PHONE NO.)
THOMAS,SUSAN 4669 SEQUOYAH RD WHEATON MD 20915	INTERNAL MEDICINE REMARKS	AAA	

27 ADMISSION DIAGNOSIS (INCLUDE BODY PART ANATOMIC SITE IF APPLICABLE)	28 MEDICAL TREATMENT FACILITY TRANSFERRED FROM	29 ORIGINAL ADMISSION DATE
DIAGNOSIS CODE	CODE	

30 CIRCUMSTANCES OF ACCIDENT, VIOLENCE, POISONING
1 ACTIVE DUTY U.S. UNIFORMED SERVICES ON DUTY (INDICATE Y OR N) CAUSE CODE
2 RECORD BRIEFLY - WHAT, WHEN, WHERE, HOW

31 DISPOSITION DATE (DAY MONTH YEAR)	32 DISPOSITION TO

33 PATIENT'S NAME (LAST, FIRST, MIDDLE)	34 GRADE RATE	35 WARD	36 REPORTING MEDICAL TREATMENT FACILITY

NOTE: BLOCKS 30, 31, 32, 38, 40, 41, 45, 48, AND 52 TO BE COMPLETED BY MEDICAL DENTAL OFFICER EXCEPT FOR CODED DATA

37 DIAG NO	38 DISPOSITION DIAGNOSIS (ES) (INCLUDE BODY PART ANATOMIC SITE IF APPLICABLE) (IF MORE THAN THREE DIAGNOSES RECORD AND CODE ON REVERSE SIDE)	39 NO OF DIAG	40 OCC RELATED (INDICATE Y OR N)	41 ERTE ACDU ONLY	42 DIAGNOSIS CODE	43 CAUSE CODE
1						
2						
3						

44 SURG	45 SURGERY PROCEDURES PERFORMED (INDICATE Y OR N) (IF MORE THAN THREE RECORD AND CODE ON REVERSE SIDE)	46 NO OF SURG PROC	47 SURGICAL CODE	48 DATE INITIAL SURGERY (DAY MONTH YEAR)
1				
2				
3				

49 DISPOSITION		50 CONVALESCENT LEAVE DAYS RECOMMENDED	51 MEDICAL TREATMENT FACILITY TRANSFERRED TO
FINAL	CODE		
01 TRANSFERRED 10 DISCHARGED TO DUTY/HOME 11 DISCHARGED CONVALESCENT LEAVE RECOMMENDED (CL) 12 DISCHARGED TO ALCOHOL REHABILITATION SERVICE (ARS) 20 DIED 30 DISCHARGED TO MEDICAL HOLDING COMPANY (MHC)			CODE

52 MEDICAL/DENTAL OFFICER'S SIGNATURE AND DATE

CODE

ADMISSION FORM (NAVY)

UH007

ADMISSION NOTIFICATION LETTER

a. Definition. The Admission Notification Letters notify the active-duty inpatient's unit commander of that patient's admission to the MTF. They are produced nightly for each inpatient whose admission was entered in AQCESS on the report date. The letters are printed alphabetically by patient name, with one letter per page. The Air Force does not use this product.

b. Format. This output is produced in letter form for the Army, and in memo form for the Navy.

c. Content. Letters for both Army and Navy begin with the military department and the name and address of the MTF.

The Army Admission Notification Letter gives the date of printing, the PAD office symbol for the MTF producing the letter, the subject of the letter ("NOTIFICATION OF HOSPITALIZATION"), and the address of the unit commander. The body of the letter states that the indicated members of the command were admitted to this facility, and gives the following information on each member: patient name, rank, SSN, date of admission, ward, and attending physician. The letter closes with the name, rank and title of the patient administration officer.

The Navy Admission Notification Letter gives the title of the patient administration officer, the title and location of the unit commander to whom the letter is addressed, and the subject ("NOTIFICATION OF HOSPITALIZATION"). The first paragraph gives the name of the member of the command who was admitted to this MTF, along with that patient's rank, SSN, date of admission, diagnosis, ward, and attending physician. Users can also indicate whether LOD misconduct determination is required. The second paragraph requests forwarding of TAD orders for duty under treatment for a period less than 30 days, and allows the MTF to request forwarding of any or all of the following: health, dental, service, or pay records, and orders or personal effects. The third paragraph of the letter gives the phone number to call in case of any questions.

DEPARTMENT OF THE ARMY
TEST ARMY MTF
SAN ANTONIO, TX 78213-2060

HSXR-PA 20 AUG 1985

SUBJECT: NOTIFICATION OF HOSPITALIZATION

COMMANDER
WRAMC
KENSINGTON, MD 20795

THE FOLLOWING MEMBER OF YOUR COMMAND WAS ADMITTED TO THIS FACILITY AS INDICATED BELOW:

PATIENT:	JONES,JOHN	MAJ 998-11-1232
DATE OF ADM:	20 AUG 1985	
WARD:	4E	
ATTEND PHYS:	STAFF	

JOHN R MICHALOWSKI
MAJ, MSC
CHIEF, PAD

ADMISSION NOTIFICATION LETTER (ARMY)

UH007

DEPARTMENT OF THE NAVY
TEST NAVY MTF, ORLANDO, FL

FROM: COMMANDING OFFICER
TO: COMMANDING OFFICER, NAVY TRAINING CENTER ORLANDO FL

SUBJECT: NOTIFICATION OF HOSPITALIZATION

1. THE FOLLOWING MEMBER OF YOUR COMMAND WAS ADMITTED TO THIS MEDICAL FACILITY AS INDICATED BELOW:

PATIENT: JONES,BOB CDR 888-33-3121
DATE OF ADM: 20 AUG 1985 DIAGNOSIS: 4611
WARD: 4E ATTENDING PHYS: STAFF
LOD MISCONDUCT DETERMINATION ( )IS, ( )IS NOT REQUIRED.

2. PLEASE FORWARD TAD ORDERS FOR DUTY UNDER TREATMENT FOR A PERIOD LESS THAN 30 DAYS. ALSO FORWARD: ( )HR, ( )DR, ( )SR, ( )PR, ( )OR, AND ( )PE AS CHECKED

3. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE PATIENT ADMINISTRATION OFFICE AT AUTOVON ROOM 2222.

BY DIRECTION

ADMISSION NOTIFICATION LETTER (NAVY)

ADMISSION SUMMARY BY NAME OR REGISTER NUMBER

a. Definition. This report summarizes all admissions effective in the report month. Users can request the Admission Summary with data in order by name or register number. It is used only by the Navy, and is printed monthly.

b. Format. The header for this report contains the run date, the MTF name, the report name and page number, and the month for which the data is effective. The body of the report is in table form.

c. Content. For each patient listed, the Admission Summary by Name gives the following data: patient name, register number, FMP, SSN, admission date, ward, clinical service, and patient category. The Admission Summary by Register Number presents the same data, but reverses the order of the patient name and register number fields. For descriptions of this data, see the Basic Data Chart. Because these reports are so similar, only an example of the Admission Summary by Name is shown here.

TEST NAVY MTF

RUN DATE: 20 AUG 1985

**** MONTHLY ADMISSIONS ****

MONTH OF AUG 1985

PAGE: 1

PATIENT NAME	REG NO	FMP	SSN	ADM DATE	WARD
CLINICAL SERVICE				PATIENT CATEGORY	
JONES,BOB	0006466	20	888-33-3121	20 AUG 1985	4E
INTERNAL MEDICINE				USN ACTIVE DUTY	
M,KID	0006465	01	002-00-2002	19 AUG 1985	
NURSERY				DEPN USN ACTIVE DUTY	
M,MOM	0006464	20	002-00-2002	19 AUG 1985	
INTERNAL MEDICINE				USN ACTIVE DUTY	
M,ONE	0006455	20	756-56-7654	07 AUG 1985	
CARDIOLOGY				USN ACTIVE DUTY	
TEST,BABY	0006460	01	222-22-2222	09 AUG 1985	
NURSERY				DEPN USN ACTIVE DUTY	
TEST,DISP REPORT	0006461	20	182-72-6123	10 AUG 1985	
INTERNAL MEDICINE				USAR ACDUTRA	
TEST,DISP REPORT	0006462	20	182-72-6123	19 AUG 1985	
INTERNAL MEDICINE				USAR ACDUTRA	
TEST,ONE	0006459	20	222-22-2222	09 AUG 1985	
OBSTETRICS				USN ACTIVE DUTY	
TEST,ONE	0006463	20	222-22-2222	16 AUG 1985	
INTERNAL MEDICINE				USN ACTIVE DUTY	
TEST,TWO	0000003	20	333-33-3333	05 AUG 1985	
CARDIOLOGY				USN ACTIVE DUTY TRAINING	

ADMISSION SUMMARY BY NAME

ALPHA ROSTER OF HOSPITAL INPATIENTS

a. Definition. This report is an alphabetical list of patients, giving demographic information about each. For this report, AQCESS selects all current inpatients, regardless of current absent status, whose admit date is on or before the report date (it excludes preadmitted patients who have not yet been admitted). The Alpha Roster is usually printed daily, and is distributed to the Information Desks to provide location information on patients.

b. Format. In addition to the standard header, this report displays the hour at which the period for this report ends. The body of Alpha Roster is presented in table form, and contains up to three lines of data on each patient, as described in the Data Chart below.

c. Content.

(1) PATIENT NAME.

(2) RANK of patient or patient's sponsor. Table 1006.

(3) REG NO. Patient's register number.

(4) SEX.

(5) WARD. ID of ward to which patient is assigned.

(6) TYPE CASE. Table 2004.

(7) CLN SVC. Code for the patient's clinical service assignment.

(8) SSN.

(9) BR OF SVC. For Army officers, the Army branch of service. For all others, the military department. Table 1023.

(10) ABS STA. Table 2002.

(11) FMP. Patient's family member prefix. Table 1012.

(12) DOB. Patient's date of birth.

(13) RELIGION. Code for patient's religious preference. Table 1000.

(14) ADMISSION DATE AND TIME.

(15) PNT CAT. Code for patient's patient category. Table 1002.

DATA CHART - ALPHA ROSTER OF HOSPITAL INPATIENTS

* * * * * ALPHA ROSTER OF HOSPITAL INPATIENTS * * * * *

PATIENT NAME / RANK / REG NO	SEX / WARD	TYPE CASE / CLN SVC	SSN / BR OF SVC / ABS STA	FMP / RELIGION / ADMISSION DATE/TIME	DOB	PNT CAT
A,BABY			748-95-5584	20	07 MAY 1985	F51
CPT	M	DIS	F	CAT		
0000282	2E	AAA	BO	23 MAY 1985 1024		
A,BABYTHREE			919-34-5900	02	30 MAY 1985	F42
	M	DIS				
0000273B	2E	ADB	BO	30 MAY 1985 1545		
A,BABYTWO			919-34-5900	01	30 MAY 1985	N42
	M	DIS				
0000273A	2E	ADB	BO	30 MAY 1985 1113		
A,MOMMYTWO			919-34-5900	30	01 MAY 1950	N42
	F	DIS				
0000273	2E	AAA	BO	30 MAY 1985 1111		
AIRMAN,SICK			789-55-4532	20	04 JAN 1961	F11
A1C	F	DIS	F	BUD		
0000190		AJD	QT	15 MAY 1985 1523		
AIRMAN,WOUNDED			954-36-4877	20	09 JUN 1964	F11
A1C	M	BC	F			
0000238	2E	ABA	BO	20 MAY 1985 0946		
BABY,SICK			423-55-6798	02	26 APR 1985	F41
	M	DIS		BAP		
0000206	4W	ADA	BO	16 MAY 1985 1457		
BRON,KEN			109-10-1001	20	12 DEC 1953	F11
AMN	M	DIS	F			
0000247	4E	AAA	BO	20 MAY 1985 1529		
BURN,ABSENT STATUS			111-00-0196	20	01 MAY 1940	F11
CPT	M	DIS	F			
0000081	2E	AJA	QT	08 APR 1985 1300		
CARROLL,JANET			293-34-3335	30	15 AUG 1956	F41
	F	DIS				
0000185	3N	AAA	BO	15 MAY 1985 1200		
CARROLL,NANCY			018-46-6563	20	16 MAY 1954	F11
COL	F	DIS	F	CAT		
0000265	4E	ACB	BO	23 MAY 1985 0812		
CHRISTENSEN,JAMES B.			562-88-5401	20	26 FEB 1928	F51
CPT	M	INJ	F			
0000087	3N	AAF	BO	09 MAY 1985 1142		

COMMAND INTEREST REPORT

a. Description. This report lists all patients who have the command interest status specified by the requestor. If the user does not specify a command interest, the report includes all command interests (patients for whom more than one command interest code has been entered will appear in more than one section of the report). This report is printed when the user requests it, is distributed to hospital headquarters, and is used to provide the command with information on specific categories of patients.

b. Format. This report contains the standard header data, except that the run date is given, but not the run time. The body of the report is arranged in table form. The report data is sorted by command interest, and within command interest, by patient name. The data is presented for no more than one command interest per page. The particular command interest status is displayed below the patient data table headings. Up to three lines of data are displayed on each patient, as described in the Data Chart below.

c. Content.

(1) PATIENT NAME.

(2) ATTEND PHYS. Short name for the patient's attending physician. Table 1004.

(3) ABS STATUS. Table 2002.

(4) ADM DIAG CODE. Code for the diagnosis made on this patient at admission. Table 9001.

(5) REG NO. Register number of patient.

(6) PT CAT. Code for patient's patient category. Table 1002.

(7) CL SVC. Code for the patient's clinical service assignment. Table 2005.

(8) ADM DIAG TEXT. Textual description of the diagnosis made on this patient at admission. Also Table 9001.

(9) RANK of the patient, if active duty military.

DATA CHART - COMMAND INTEREST REPORT

(10) WARD.

(11) FMP. Patient's family member prefix. Table 1012.

(12) SSN.

DATA CHART - COMMAND INTEREST REPORT

PERSONAL DATA - PRIVACY ACT 1974

TEST NAVY MTF 31 AUG 1985

* * * * * COMMAND INTEREST REPORT * * * * *

PATIENT NAME		REG NO	PT CAT	RANK	FMP SSN
	ABS STATUS		CL SVC	WARD	
ATTEND PHYS	ADM DIAG CODE	ADM DIAG TEXT			
		COM			
MOORE,TED		0006473	N11	CPT	20 003-99-4004
	BO		AAA	4S	
STAFF					
WALKER,LARRY		0006480	N11	DN	20 231-83-0293
	BO		AAA	4S	
JOHNS	8070	FX RIBS CLOSED			

COMMAND INTEREST REPORT

DAILY ADMISSIONS BY DIAGNOSIS

a. Definition. The Daily Admissions by Diagnosis Report lists all patients whose admissions were entered into AQCESS on the report date, and gives demographic and diagnosis data on each patient. If no admission diagnosis was entered for a patient, data on that patient appears at the end of the report. The Daily Admissions Report is usually printed daily, and is distributed as determined by the MTF command. It is used in workload evaluation.

b. Format. This report contains the standard header data, except that the run date is shown without the run time, and the report title is followed by the date for which the report is being run. The report data is sorted by admission diagnosis code and, within code, by patient name. The admitting diagnosis code and description are shown on the left side, followed by data on each patient for whom that was the admitting diagnosis, as described in the Data Chart below.

c. Content.

(1) DIAG: CODE. Code for the admitting diagnosis. Table 9001.

(2) DESC. Textual description of the admitting diagnosis. Table 9001.

(3) ADMITTING PHYSICIAN. Short name of the physician who admitting the patient.

(4) REG NO. Register number of the patient.

(5) PNT NAME.

(6) FMP. Patient's family member prefix. Table 1012.

(7) SSN.

(8) RANK of patient, if active duty.

(9) WARD.

(10) CLN SVC. Code for the patient's clinical service assignment. Table 2005.

DATA CHART - DAILY ADMISSIONS BY DIAGNOSIS REPORT

TEST NAVY MTF RUN DATE: 31 AUG 1985

PERSONAL DATA - PRIVACY ACT 1974

* * * * ADMISSIONS (BY DIAGNOSIS) ENTERED 30 AUG 1985 * * * *

PNT NAME / REG NO / DIAG:CODE	DATE OF ADM / DESCRIPTION	FMP SSN / ADMITTING PHYSICIAN	RANK	WARD	CLN SVC
SANTOS,MANUEL		20 238-19-2828	ENS		
0006488	11 JUL 1985	JONES, BRADFORD, M.D.			AAA
1208	SCHISTOSOMIASS NEC				
KUSHNIK,HARRY		55 248-18-2983			
0006478	30 AUG 1985	DILLON, JOHN		4S	AAB
4130	ANGINA PECTORIS				
JOHNSON,SAM		20 241-92-8342	CW3		
0006477	30 AUG 1985	BERNARD,EDWARD M.D.		4S	AAF
5310	GASTRIC ULCER, ACUTE WITH HEMORRHAGE				
BERTRAM,JOHNNY		02 392-89-1823			
0006482	30 AUG 1985	JOHNS, MIKE		5U	ADA
5410	APPENDICITIS, UNQUALIFIED				
GEORGE,STEPHANIE		30 293-81-2828			
0006485	28 AUG 1985	BERNARD,EDWARD M.D.		4S	AAA
5410	APPENDICITIS, UNQUALIFIED				
ROGERS,STEVEN		02 291-82-1982			
0006484	30 AUG 1985	BROWN, MARCIA		5S	ABC
8000	FX VAULT SKULL CL				
WALKER,LARRY		20 231-83-0293	DN		
0006480	20 AUG 1985	JOHNS, MIKE		4S	AAA
8070	FX RIBS CLOSED				
HARVEY,BILL		30 231-92-8317			
0006486	20 JUL 1985	BERNARD,EDWARD M.D.			AAA
LINDEMAN,ERIC		20 342-98-4747	ENS		
0006490	24 JUL 1985	BLACK,BRUCE			AAA
LUCAS,WILLIAM		20 349-58-2717	CPT		
0006489	25 JUL 1985	BLACK, JOHN			AAA
WILLIAMS,CARL		20 129-23-1829	CPT		
0006487	30 AUG 1985	BERNARD,EDWARD M.D.			AAA
BELLAMY,LAURA		30 290-12-1921			
0006483	30 AUG 1985	JOHNS, MIKE		4E	ACB
V220	NORML PRIMIGRAVIDA				
FRANKLIN,SANDRA		30 342-81-9384			
0006479	30 AUG 1985	JONES, BRADFORD, M.D.		4E	ACB
V220	NORML PRIMIGRAVIDA				

DAILY ADMISSIONS BY DIAGNOSIS REPORT

DEATH REPORT

a. Definition. This report gives information on deaths occurring in the MTF. Record of a death appears on this report only when (1) Clinical Records processing has begun on that record, (2) the type of disposition indicates death (flag 1 = 2), and (3) the disposition date falls within the report period. Data for this report is sorted by disposition date and, within date, by patient name. The Death Report is produced on request.

b. Format. The header for this report contains the MTF name, the run date, the Privacy Act Statement, and the report name. The body of the report is in table form and contains the data described below.

c. Content.

(1) DISP DATE. Date of patient's disposition.

(2) ADM DATE. Date of patient's admission.

(3) DISP: TYPE. The patient's disposition status at the end of hospitalization. Textual description. Table 2007. For this report, this field will indicate that the patient died.

(4) PATIENT NAME.

(5) CLN SVC. Code for the clinical service to which the patient was assigned. Table 2005.

(6) CODE. Code of the diagnosis indicated as the cause of death. Table 9001.

(8) WARD. ID of the ward to which the patient was assigned.

(7) TEXT. Text describing the diagnosis indicated as the cause of death. Table 4001.

(8) REG NO. Patient's register number.

(9) ATTEND PHY. Patient's attending physician.

(10) FMP.

(11) SSN.

(12) TOT HOSP DAYS. Total number of days the patient spent in the MTF.

(13) PNT CAT. Code for the patient's patient category. Table 1002.

DATA CHART - DEATH REPORT

TEST NAVY MTF RUN DATE: 20 AUG 1985

PERSONAL DATA - PRIVACY ACT 1974

HOSPITAL DEATH REPORT

DISP DATE / ADM DATE / DISP: TYPE	PATIENT NAME / CLN SVC / CODE	WARD / TEXT	REG NO / ATTEND PHY	FMP	SSN / TOT HOSP DAYS	PNT CAT
20 AUG 1985	JONES,BOB		0006466	20	888-33-3121	N11
20 AUG 1985	AAA	4E	NEWMAN		1	
DIED	4151	PULMONARY EMBOLISM				

DEATH REPORT

a. Definition. This output is printed to notify Army unit commanders of any active-duty enlisted in their commands whose dispositions were entered into AQCESS on the report date. Disposition Letters are printed alphabetically by patient name, with one letter per page. They are produced nightly.

b. Format. This product is in letter form.

c. Content. The letter begins with the name of the military department and the name and address of the MTF sending the letter. It gives the date of printing, the PAD office symbol for the MTF, and the subject ("RELEASE FROM HOSPITALIZATION" and the patient's name, rank, and SSN). Then it gives the address of the unit commander to whom the letter is addressed. The text of the letter states that the subject enlisted member was discharged on the date shown, and breaks down the subsistence days for this hospitalization into the categories TOTAL DAYS OF HOSPITALIZATION, NUMBER OF SUBSISTENCE DAYS CHARGED, and NUMBER OF NON-CHARGEABLE DAYS. The letter concludes with the name, rank, and title of the MTF's patient administration officer.

DEPARTMENT OF THE ARMY
TEST ARMY MTF
SAN ANTONIO, TX 78213-2060

HSXR-PA 20 AUG 1985
SUBJECT: RELEASE FROM HOSPITALIZATION: TAYLOR,FRANK
SSG 998-11-1232

COMMANDER
WRAMC
KENSINGTON , MD 20795

SUBJECT ENLISTED MEMBER WAS DISCHARGED FROM HOSPITALIZATION ON 20 AUG 1985.
SUBSISTENCE DAYS FOR THIS HOSPITALIZATION ARE INDICATED BELOW:

TOTAL DAYS OF HOSPITALIZATION:	1
NUMBER OF SUBSISTENCE DAYS CHARGED:	1
NUMBER OF NON-CHARGEABLE DAYS:	0

JOHN R MICHALOWSKI
MAJ. MSC
CHIEF, PAD

DISPOSITION SUMMARY BY NAME OR REGISTER NUMBER

a. Definition. This report summarizes all dispositions effective in the report month. Users can choose to print the Disposition Summary with data in order by name or register number. This product is used only by the Navy, and is printed monthly.

b. Format. The header for this report contains the run date, the MTF name, the report name and page number, and the month for which the data is effective. The body of the report is in table form.

c. Content. For each patient listed, the Disposition Summary by Name gives the following data: patient name, register number, clinical service, disposition date, days (the number of days the patient spent in the MTF), source of admission, type of disposition, and patient category description. The Disposition Summary by Register Number presents the same data, but reverses the order of the patient name and register number fields. For descriptions of this data, see the Basic Data Chart. Because these reports are so similar, only an example of the Disposition Summary by Register Number is shown here.

TEST NAVY MTF RUN DATE: 20 AUG 1985

**** MONTHLY DISPOSITIONS **** PAGE: 1

MONTH OF AUG 1985

REG NO	PATIENT NAME	DISP DATE	DAYS	SRC ADM	TYPE DISP
	CLINICAL SERVICE		PATIENT CATEGORY		
0000003	TEST,TWO	07 AUG 1985	2	FTM	HOME
	CARDIOLOGY		USN ACTIVE DUTY TRAINING		
0006459	TEST,ONE	15 AUG 1985	6	DIR	HOME
	OBSTETRICS		USN ACTIVE DUTY		
0006460	TEST,BABY	09 AUG 1985	1	LB	DIED
	NURSERY		DEPN USN ACTIVE DUTY		
0006461	TEST,DISP REPORT	15 AUG 1985	5	DIR	HOME
	INTERNAL MEDICINE		USAR ACDUTRA		
0006464	M,MOM	19 AUG 1985	1	DIR	HOME
	INTERNAL MEDICINE		USN ACTIVE DUTY		
0006465	M,KID	19 AUG 1985	1	LB	HOME
	NURSERY		DEPN USN ACTIVE DUTY		

DISPOSITION SUMMARY BY REGISTER NUMBER

EMBOSSED CARD

TO BE SUBMITTED AT A LATER DATE

RESERVED FOR EMBOSSED CARD

INDEX CARD (3x5 CARD or 5x8 CARD)

a. Definition. The Index Card contains registration data on an individual patient. It is produced automatically when a patient is admitted (in the Air Force and Army systems), and when requested by the user from the Registration process, Inpatient Products segment, for all three military departments. Index Cards are printed in sets. The number of cards in a set is specified by the MTF. The number entered by the user when requesting this product determines how many sets of Index Cards will be produced.

Distribution of the Index Cards is determined by the MTF command; these cards are used to provide demographic and diagnostic information about the patient.

b. Format. The Army and Air Force use a 3x5 Index Card; the Navy uses a 5x8 card. The header for the 3x5 Card consists only of the Privacy Act Statement; no trailer is used. The header for the 5x8 Card consists of the title "Inpatient Information Card," the MTF name, and the Privacy Act Statement. The trailer for the 5x8 Card contains the patient's name, FMP, SSN, register number, patient category, religion, and ward. This trailer can be cut and used as a wristband insert.

c. Content. The data used in the two versions of the Index Card differs for each military department. A separate Data Chart is included for each type of card.

(1) REG NO. Register number of patient.

(2) PATIENT NAME.

(3) RANK of patient, if active duty.

(4) FMP. Family member prefix of patient. Table 1012.

(5) SSN.

(6) WARD.

(7) TYPE CASE. Table 2004.

(8) SEX of patient.

(9) RELIGIOUS PREFERENCE. Table 1000.

(10) RACE. Table 1024.

(11) MILITARY DEPARTMENT. If active duty. Table 1023.

(12) DATE OF BIRTH of patient.

(13) SOURCE OF ADMISSION. Table 2001.

(14) NEXT OF KIN. Name of patient's next of kin.

(15) RELATIONSHIP of next of kin to patient.

(16) ADDRESS OF PATIENT'S NEXT OF KIN. Street, city, state, and zip code.

(17) PATIENT CATEGORY. Code. Table 1002.

(18) DATE AND TIME OF ADMISSION.

(19) ATTENDING PHYSICIAN for this patient.

(20) CLINICAL SERVICE. Code indicating patient's clinical service assignment. Table 2005.

DATA CHART - INDEX CARD (3x5 CARD) (ARMY AND AIR FORCE)

PERSONAL DATA - PRIVACY ACT 1974

0000109 SHARANSKY,HARRY MSG
20 444-38-2929
3S DIS M 5 11 SEP 1945 DIR

SHARANSKY, MOLLIE WIFE
13 BENTON ST
ALEXANDRIA VA 22312

A12 10 JUN 1985 1000 COOKE MIKE AAAA

INDEX CARD (3x5 CARD) (ARMY AND AIR FORCE)

UH007

(1) PATIENT NAME.

(2) FMP.

(3) SSN.

(4) DOB. Patient's date of birth.

(5) WARD. ID of patient's ward assignment.

PERSONAL

(6) PATIENT CAT. Description of patient's patient category. Table 1002.

(7) RELIGION. Table 1000.

(8) RACE. Table 1024.

(9) MARITAL STATUS.

(10) SEX of patient.

(11) MIL. OCCUPATION. Code for patient's military occupation or specialty. Table 1029.

(12) GRADE. Patient's pay grade. Translated from patient's rank.

(13) LENGTH SERVICE. In the format YYMM, e.g., 0410 = 4 years and 10 months (from 0000 to 5511).

(14) MIL. TH. OPS. Military theater of operations. Table 2008.

(15) PATIENT ADDRESS. Street, city, state, and zip code.

(16) ADDRESS OF NEXT OF KIN. Street, city, state, and zip code.

(19) DUTY ADDRESS: UIC SHIP. Unit Identification Code of patient's duty assignment.

DATA CHART - INDEX CARD (5x8 CARD) (NAVY)

(20) EMERGENCY ADDRESS PHONE.

(21) DUTY ADDRESS. Street, city, state, and zip code.

ADMISSION

(22) SRCE. Source of admission. Table 2001.

(23) DATE/TIME of admission.

(24) CLINICAL SVC. Code for the patient's clinical service assignment. Table 2005.

(25) CMD INTEREST. Code for the patient's command interest status. Table 1016.

(26) PHYSICIAN. Name of patient's attending physician.

(27) DIAGNOSIS. Description of the patient's admitting diagnosis. Table 9001.

(28) CODE for the patient's admitting diagnosis. Table 9001.

(29) ORIG. ADM. DATE. If patient is a transfer-in, the date on which the patient was admitted to previous MTF.

(30) RECORD RECEIVED: PERSONAL EFFECTS, HEALTH, DENTAL, SERVICE, ORDERS, PAY. Indicates which of these items have been received by the MTF: personal effects (PE), health record (HR), dental record (DR), service record (SR), orders (ORD), pay record (PR).

(31) CIRCUMSTANCES OF ACCIDENT, VIOLENCE OR POISONING: CODE. Code indicating cause of injury, if any. Description of the cause or injury appears on the next line. Table 2009.

(32) ON DUTY. Indicates whether this injury occurred while the patient was on duty.

DATA CHART - INDEX CARD (5x8 CARD) (NAVY)

INPATIENT INFORMATION CARD - NJ PORTSMOUTH, VA
*** PERSONAL DATA - PRIVACY ACT 1974 ***

HOBBY,CHARLES 20 214-56-7812 DOB 09 AUG 1948 WARD 3S

PERSONAL			ADMISSION		
PATIENT CAT ACDU-N			SRCE DIR DATE/TIME 20 AUG 1985 0640		
RELIGION			CLINICAL SVC. ABF		
RACE CAUCAS	MARITAL STATUS	M	CMD. INTEREST LOD		
SEX MALE	MIL. OCCUPATION	16	PHYSICIAN DAVID KATZ		
GRADE 04	LENGTH SERVICE	1502	DIAGNOSIS FX MANDIBLE OPEN		
	MIL. TH. OPS.	99	CODE 8023		
			ORIG. ADM. DATE		
PATIENT ADDRESS					
13 LIVINGSTON					
ALEXANDRIA	VA 22312		RECORD RECEIVED		
			PERSONAL EFFECTS		HEALTH
NEXT OF KIN-PHONE			DENTAL		SERVICE
HOBBY,JANE	WIFE		ORDERS		PAY
13 LIVINGSTON					
ALEXANDRIA	VA 22312				
DUTY ADDRESS-UIC SHIP 22312			EMERGENCY ADDRESS PHONE		
13 HARDEN RD					
MCLEAN	VA 24218				

CIRCUMSTANCES OF ACCIDENT, VIOLENCE OR POISONING CODE 111 ON DUTY Y

MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO PASSENGER (EXCEPT 116,117)

HOBBY, CHARLES 20 214-56-7812
0000176 ACDU-N WARD: 3S

INDEX CARD (5x8 CARD) (NAVY)

INJURY REPORT

a. Definition. The Injury Report lists each patient whose type case indicates injury, and gives demographic data on the patient. The report includes data on each patient with an injury type case whose admission date falls within the report period. Injury type cases are selected based on the flag value of the type case code; if flag 1 = 1, the case is selected. This report is printed on request and is distributed to the casualty clerk and the safety office.

b. Format. This report contains the standard header data. The report's content is arranged in table form, with table headings first, followed by the TYPE CASE code, followed by data on each patient having that type case. The patient data is described in the Data Chart below.

c. Content.

(1) PATIENT NAME.

(2) ADDRESS.

(3) UNIT ADDRESS.

(4) CAUSE INJ: CODE. The code for the cause of injury. Table 2009.

(5) TEXT. The textual description of the cause of injury. Table 2009.

(6) FMP. Patient's family member prefix. Table 1012.

(7) SSN.

(8) REG NO. Patient's register number.

(9) RANK of patient.

(10) ADM: DATE. Date of admission.

(11) DIAG. Code for patient's admission diagnosis. Table 9001.

(12) HOME PHONE.

(13) WORK PHONE.

DATA CHART - INJURY REPORT

DEWITT ACH RUN DATE: 13 JUN 1985

PERSONAL DATA - PRIVACY ACT 1974

INJURY REPORT

PATIENT NAME FMP SSN REG NO RANK ADM: DATE DIAG
ADDRESS HOME PHONE
UNIT ADDRESS WORK PHONE
CAUSE INJ: CODE TEXT:

EXR

DEPENDENT,SPONSOR OF 20 238-91-7878 0000093 1LT 06 JUN 1985
13 HEALTH DR ALEXANDRIA VA 223121234

441
PERSONAL INJURY ON LAND/UNSPEC BY ROCKET

CAUSE,ASDF 20 444-56-8989 0000103 1LT 25 MAY 1985
ASDFASDF ALEXANDRIA VA 22312
ALEXANDRIA VA 22312

000
AIR ACCIDENT, FIXED-WING MILITARY, BOARDING OR ALIGHTING

INJURY REPORT

LONG-TERM PATIENT ROSTER

a. Definition. The Long-Term Patient Roster lists current inpatients who have been under hospital care for more than the number of days specified by the person requesting the report. Data on this report is sorted by patient name. *The report is printed on request.*

b. Format. The Long-Term Patient Roster contains the standard header data, with the report title including the number of days of hospitalization specified by the requestor. The body of the report displays the data described below, in table form.

c. Content.

(1) PATIENT NAME.

(2) WARD. Ward to which the patient is assigned.

(3) DIAG. Description of the patient's diagnosis. From Table 9001.

(4) ABS STATUS. Table 2002.

(5) CL SVC. Patient's clinical service assignment. Table 2005.

(6) REG NO. Patient's register number.

(7) PHYSICIAN. Patient's attending physician. Table 1004.

(8) SSN.

(9) RANK. Table 1006.

(10) PROJ DISP: DATE and TYPE. Date and type of the projected disposition entered for this patient, if any.

(11) PSS/MHC. Patient's command interest status, if any. Table 1016.

(12) MEB STATUS. Patient's Medical Evaluation Board status, if any. Table 2010.

(13) HOSPITAL DAYS: THIS MTF. Number of days the patient has spent at this MTF.

(14) TOTAL. Number of days the patient has spent on this inpatient episode. *Will be different from (13) if the patient is a transfer-in.*

DATA CHART - LONG-TERM PATIENT ROSTER

TEST NAVY MTF

RUN DATE: 20 AUG 1985

PERSONAL DATA - PRIVACY ACT 1974

PAGE: 1

LIST OF CURRENT INPATIENTS HOSPITALIZED OVER: 5 DAYS

PATIENT NAME / WARD / DIAG	ABS STATUS	CL SVC	REG NO / PHYSICIAN	SSN / PROJ DISP: DATE	RANK / TYPE	PSS/MHC	MEB STATUS / HOSP DAYS: THIS MTF	TOTAL
M,ONE			0006455	756-56-7654	CPT	PDP		
CL	AAB		STAFF					
SCHIZOPHRENIA, PARANOID T							13	13

LONG-TERM PATIENT ROSTER

PATIENT CHARGE ROSTER

a. Definition. This report lists current charges for all inpatients or patients dispositioned on the run date. Its data is sorted by patient name. The Patient Charge Roster is used by the Army only, and is printed nightly.

b. Format. This report includes the standard header data. The body of the report is in table form.

c. Content.

(1) PATIENT NAME.

(2) REG. Patient's register number.

(3) PT CAT. Table 1002.

(4) ADM DATE.

(5) DAYS N-C. The number of days the patient spent in the MTF for which no charges have accrued.

(6) C. The number of days the patient spent in the MTF for which charges have accrued.

(7) RATE. The charge rate for the inpatient episode.

(8) TOTAL CHARGE. The total amount charged for the patient.

DATA CHART - PATIENT CHARGE ROSTER

PATIENT CHARGE ROSTER

PATIENT NAME	REG	PT CAT	ADM DATE	DAYS N-C	DAYS C	RATE	TOTAL CHARGE
BLACKWELL,JAMES	0003437	A11	27 JUL 1985	23	12	3.80	45.60
EVERETT,SAM	0003443	A12	30 AUG 1985	0	1	3.80	3.80
MORLEY,ANDREA	0003439	A51	27 AUG 1985	0	4	6.80	27.20
MORLEY,ANDREW	0003440	N51	28 AUG 1985	3	0	6.80	.00
RIVERTON,DALLAS	0003438	A12	30 AUG 1985	0	1	3.80	3.80

PATIENT CHARGE ROSTER

PATIENT STRENGTH REPORT

See A&D Recap.

a. Definition. This report lists and gives data on each current preadmission. It is printed on request and is distributed to A&D and to any other sites as directed by the MTF command. This report is used to evaluate expected workload.

b. Format. The header for this report contains the standard data, and the body is arranged in table form, containing up to two lines of data on each preadmission, as described in the Data Chart below. The data is sorted by expected admission date and, within date, by patient name.

c. Content.

(1) ADM DATE. Patient's admission date.

(2) ADM DIAG. The description of the diagnosis made on this patient at admission. Table 9001.

(3) PATIENT NAME.

(4) CL SVC. Code for the patient's clinical service assignment. Table 2005.

(5) WARD. ID of the patient's ward assignment.

(6) ADM PHYS. Name of the patient's admitting physician.

DATA CHART - PREADMISSION LIST

PREADMISSION LIST

ADM DATE / ADM DIAG	PATIENT NAME	CL SVC	WARD	ADM PHYS
30 MAY 1985	SMITHERS,JOYCE	AAA		
04 JUN 1985 SINGLE LIVEBIRTH, HOSPITAL	FOSTER,ANITA	AAC		

PREADMISSION LIST

PROJECTED DISPOSITIONS BY AFSC/MOS REPORT

a. Definition. The Projected Dispositions Report presents data on patients for whom projected dispositions have been entered in AQCESS. The data is sorted by the patient's military specialty and, within each specialty category, by patient's name. This report is printed on request.

b. Format. The header for this report contains the MTF name, run date, and report title. The body of the report is in table form, and contains the data described below.

c. Content.

(1) SPEC. Patient's military specialty or occupation. Table 1029.

(2) NAME.

(3) PNT CAT. Table 1002.

(4) RANK. Table 1006.

(5) TYPE DISP. Type of disposition projected. Table 2007.

(6) DATE DISP. Date of disposition projected.

(7) DIAG. Admitting diagnosis entered for this patient. Table 9001.

DATA CHART - PROJECTED DISPOSITIONS BY AFSC/MOS REPORT

TEST NAVY MTF RUN DATE: 20 AUG 1985

PROJECTED DISPOSITIONS BY AFSC/MOS

SPEC	NAME	PNT CAT	RANK	TYPE DISP	DATE DISP	DIAG
22	BAKER,HAROLD	N11	CDR	HOME	24 AUG 1985	
01	MYERS,PETER	N11	CPT	HOME	27 AUG 1985	2953
02	WHITE,BARRY	N11	CPT	CL	22 AUG 1985	

PROJECTED DISPOSITIONS BY AFSC/MOS REPORT

REGISTER OF PATIENTS

a. Definition. This report is a register number assignment log. For each day of the reporting period indicated by the user, the report lists the register numbers assigned and gives summary patient data for each. The data is sorted in chronological order by the date on which the admission was entered in AQCESS and, under each date, data is arranged in ascending order by register number. The Register of Patients is printed on request, and can be used in place of DD739.

b. Format. In addition to the standard header data, this report gives the starting and ending dates of the reporting period. The body of the report is in table form, and contains the data described below.

c. Content. The lefthand column of this report gives the dates when the register numbers were assigned. Then the report gives the register numbers assigned on each date, and the name, FMP, SSN, and admission date and time of each patient.

TEST NAVY MTF

RUN DATE 20 AUG 1985
PAGE 1

PERSONAL DATA - PRIVACY ACT 1974

REGISTER OF PATIENTS ADMITTED
FROM 01 AUG 1985 THRU 20 AUG 1985

DATE ENTERED / REG NO	PNT NAME	FMP	SSN	ADM DATE/TIME
07 AUG 1985				
0000003	TEST,TWO	20	333-33-3333	05 AUG 1985 1000
0006455	M,ONE	20	756-56-7654	07 AUG 1985 1159
09 AUG 1985				
0006459	TEST,ONE	20	222-22-2222	09 AUG 1985 1350
0006460	TEST,BABY	01	222-22-2222	09 AUG 1985 1351
13 AUG 1985				
0006458	TEST,NAVY	20	883-11-1222	14 JUL 1985 1200
15 AUG 1985				
0006461	TEST,DISP REPORT	20	182-72-6123	10 AUG 1985 1200
19 AUG 1985				
0006462	TEST,DISP REPORT	20	182-72-6123	19 AUG 1985 1339
0006463	TEST,ONE	20	222-22-2222	16 AUG 1985 1200
0006464	M,MOM	20	002-00-2002	19 AUG 1985 1544
0006465	M,KID	01	002-00-2002	19 AUG 1985 1545
20 AUG 1985				
0006466	JONES,BOB	20	888-33-3121	20 AUG 1985 0640

REGISTER OF PATIENTS

UH007

REGISTRATION FORM

a. Definition. This product contains registration data on an individual patient. It is requested by the user from the Registration function, Outpatient Products segment.

b. Format. This is a single-page form with the following header information:

- AQCESS VERSION NUMBER. The AQCESS software version number.
- PRIVACY ACT STATEMENT.
- LAST UPDATE. Date when this patient record was last updated.
- MTF NAME.
- RUN DATE.
- OUTPUT NAME.

The body of the Registration form contains the patient data described below.

c. Content.

(1) NAME. Patient name.
(2) DATE OF BIRTH.
(3) SEX.
(4) RACE. Table 1024.
(5) FAMILY MEMBER PREFIX. Table 1012.
(6) SPONSOR NAME.
(7) SPONSOR SSN.
(8) PATIENT CATEGORY. Code. Table 1002.
(9) SPONSOR GRADE. Table 1006.
(10) PATIENT OCCUPATION.

DATA CHART - REGISTRATION FORM

(11) DUTY TELEPHONE.

(12) HOME TELEPHONE.

(13) SPONSOR MIL DUTY ADDR. Duty address of the patient, if a sponsor.

(14) PATIENT MAILING ADDRESS.

(15) PRIMARY CARE MTF. Table 1005.

(16) REG NO LAST ADM THIS MTF. Patient's previous register number, if this patient has previously been admitted to this MTF.

(17) DATE LAST ADM THIS MTF. Date on which patient was previously admitted.

(18) REGISTRATION REMARKS. Free text.

(19) DATE VERIFIED W/PNT. Date on which the registration data was verified by patient or patient's agent, via the Registration function.

(20) FLYING STATUS. Flying status or aviation service code of patient.

(21) FMP. Patient's family member prefix.

(22) SSN. Sponsor's Social Security Number.

DATA CHART - REGISTRATION FORM

VERSION 1.00 **** PERSONAL DATA **** LAST UPDATE 05 JUL 19[illegible]
TRAINING HOSPITAL * PRIVACY ACT OF 1974 * RUN DATE 05 JUL [illegible]35

PATIENT REGISTRATION FORM

NAME: ROBINSON, JOHN

DATE OF BIRTH: 07 FEB 1905

SEX: M

RACE: C

FAMILY MEMBER PREFIX: 20

SPONSOR NAME: ROBINSON, JOHN

SPONSOR SSN: 678-44-1234

PATIENT CATEGORY: N11

SPONSOR GRADE: CPT

PATIENT OCCUPATION:

DUTY TELEPHONE:

HOME TELEPHONE:

SPON MIL DUTY ADDR:
WALTER REED AMC
WASHINGTON DC 20009

PATIENT MAILING ADDRESS:
909 WELLS ST
ALEXANDRIA VA 22312

PRIMARY CARE MTF:

REG NO LAST ADM THIS MTF:

DATE LAST ADM THIS MTF:
REGISTRATION REMARKS:

DATE VERIFIED W/PNT:

FLYING STATUS: 20 678-44-1234

REGISTRATION FORM

ROSTER OF VSI/SI/SC PATIENTS

a. Definition. The Roster of VSI/SI/SC Patients lists, by ward and clinical service, all current inpatients whose casualty status code is Very Seriously Ill, Seriously Ill, Special Category, or Terminally Ill. This report includes demographic data, diagnosis, and prognosis for each patient. It is usually printed daily, and is distributed to the casualty clerk and to other sites as directed by the command.

b. Format. The header of this report contains the standard data, and the body of the report is arranged in table form, with up to two lines of data on each patient.

c. Content.

(1) WARD.

(2) RANK. Table 1006.

(3) RELIGION. Table 1000.

(4) PATIENT NAME.

(5) REG NO. Patient's register number.

(6) CASUALTY: STA. Patient's casualty status. Indicates the seriousness of the patient's condition. Will contain a code for Very Seriously Ill, Seriously Ill, Special Category, or Terminally Ill. Table 2011.

(7) DIAGNOSIS. The textual description of the patient's diagnosis. Table 9001.

(8) DATE of patient's admission.

(9) REC POS. Recovery possibility or prognosis. Table 2013.

DATA CHART - ROSTER OF VSI/SI/SC PATIENTS

DEWITT ACH

* * * * * ROSTER OF VSI/SI/SC PATIENTS BY WARD AND CLINICAL SERVICE * * * * *

WARD	CLN SVC	PATIENT NAME	CASUALTY: STA	DATE	REC POS
RANK	RELIGION	REG NO	DIAGNOSIS		
3S	AAAA	DAVIDSON,HARLEY	SC	13 JUN 1985	CI
PV1		0000106	SKULL FRACTURE		
6S	AAAA	ROBINSON,JOHN	SI	13 JUN 1985	CU
		0000107	MYOCARDIAL INFARCT ACUTE		

ROSTER OF VSI/SI/SC PATIENTS

STATUS OUT ROSTER

a. Definition. This report lists patients currently out of the hospital, giving their expected return dates, and indicating whether return is overdue. It is used to monitor those patients who are not physically in the MTF. The Status Out Roster is printed on request, and its distribution is determined by the MTF command.

b. Format. The header of this report contains the standard data, and the body of the report is arranged in table form, with up to two lines of data on each patient.

c. Content.

(1) RTN DATE. The date on which this patient is expected to return to the MTF.

(2) PATIENTS: NAME. Name of patient.

(3) SEX.

(4) CLINICAL SVC. Code for the patient's clinical service assignment. Table 2005.

(5) CAT. Code for the patient's patient category. Table 1002.

(6) REG NBR. Patient's register number.

(7) STAT. Code for the patient's absent status. This field will contain any absent status except "BO" (bed occupied). Table 2002.

(8) DAYS ON. Number of days the patient has had this absent status.

(9) OVERDUE. Number of days the patient has remained out of the hospital (i.e., with this absent status) past the return date.

DATA CHART - STATUS OUT ROSTER

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE: 31 AUG 1985

TEST NAVY MTF

* * * * * STATUS OUT ROSTER * * * * *

RTN DATE	PATIENTS: NAME SEX	CLINICAL SVC	CAT	REG NBR	STAT:	DAYS ON	OVERDUE
24 AUG 1985	LUCAS,WILLIAM M	AAA	N11	0006489	SE	14	7
31 AUG 1985	SANTOS,MANUEL M	AAA	N11	0006488	CL	41	0
02 SEP 1985	LINDEMAN,ERIC M	AAA	N11	0006490	AM	31	-2
10 SEP 1985	WILLIAMS,CARL M	AAA	N11	0006487	CC	11	-10

STATUS OUT ROSTER

UCA DISPOSITION REPORT

a. Definition. This report gives the number of patients who have been dispositioned during a given month, by UCA clinical service code. It is used to report to DoD on hospital discharges. This report is usually produced monthly, and its distribution is determined by the MTF command and by DoD.

b. Format. In addition to the standard data, the header includes the month for which the report data is effective. The body of the report is arranged in table form.

c. Content.

(1) CLINICAL SERVICE CODE. See Table 2005.

(2) TITLE. Name of the clinical service. Table 2005.

(3) # OF PATIENTS. Number of patients on each clinical service who were dispositioned during the month.

DATA CHART - UCA DISPOSITION REPORT

TRAINING HOSPITAL

RUN DATE: 05 JUL 1985
PAGE: 1

PERSONAL DATA - PRIVACY ACT 1974

UCA DISPOSITION REPORT

REPORT MONTH: JUN 1985

----- CLN SVC ----- CODE	TITLE	# OF PATIENTS
AAAA	INTERNAL MEDICINE	12
AAAB	INFECTIOUS DISEASE	4
AADA	DERMATOLOGY	2
ABAA	GENERAL SURGERY	1
ACBA	LABOR/DELIVERY	1
ADBA	NURSERY	1
CRD	CARDEX FOR RECORD ONLY	2
		23

UCA DISPOSITION REPORT

UCA INPATIENT OCCUPIED BED DAYS REPORT

a. Definition. This report gives the number of bed days accumulated for each clinical service and ward for a given month. It also shows the total number of bed days per clinical service, total bed days per ward, and a grand total of all bed days for the month.

The UCA Bed Days Report includes data on each person who was an inpatient during the report month. It is normally run after month-end. If it is run for the current month, it will report on bed days to date.

The UCA Bed Days Report is used to report to DoD on hospital beds occupied. It is usually printed monthly, and its distribution is determined by the MTF command and by DoD.

b. Format. In addition to the standard data, the header includes the month for which the report data is effective. The body of the report is arranged in table form.

c. Content. This report lists the MTF's clinical services in the left column and the MTF's wards across the top of the page. The body of the report consists of the number of bed days accumulated for each ward/clinical service combination. The bottom row on each page gives the total number of bed days accumulated on each ward. On the last page of the report, the right-hand column shows the total number of bed days accumulated on each clinical service for the entire report; the bottom right-hand block of this column contains the total number of bed days accumulated during the month for all the wards and clinical services in the MTF.

UH007

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE 05 JUL 1985 1345

TRAINING HOSPITAL REPORT MONTH: JUN 1985 PAGE 1

* * * * * MONTHLY RECAP - INPATIENT OCCUPIED BED DAYS * * * * *

UCA INPATIENT OCCUPIED BED DAYS REPORT

CODE	TITLE	25E	2D	2F	2K	2W	30N	32W	35E	3N	3S	3W	44C	49W	4I	4K	4S	4W	5E	5S	5T
AAAA	INTERNAL MEDIC	30	0	0	0	0	30	0	0	0	107	0	0	0	160	0	1	0	48	0	0
AAAB	INFECTIOUS DIS	0	0	4	0	9	0	0	0	0	11	0	0	0	41	0	6	0	0	6	0
AAAC	ALLERGY	0	0	0	0	0	0	0	0	0	0	0	0	0	13	0	0	0	0	0	0
AABA	CARDIOLOGY	0	0	0	0	0	0	0	0	0	0	0	0	0	13	0	0	0	0	0	0
AADA	DERMATOLOGY	0	0	2	0	0	0	0	0	0	20	0	0	0	0	0	0	0	0	0	0
AAGA	HEMATOLOGY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AAHA	ONCOLOGY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ABAA	GENERAL SURGER	0	0	2	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0
ABDA	NEUROSURGERY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ABFA	ORAL SURGERY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ACBA	LABOR/DELIVERY	0	0	0	0	0	0	0	0	0	0	0	0	0	32	0	0	0	0	0	0
ADBA	NURSERY	0	0	14	0	0	0	0	0	0	8	0	0	0	45	0	0	0	0	30	0
AEAA	ORTHOPEDICS	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL		30	0	24	0	9	30	0	0	0	142	0	0	0	309	0	7	0	48	36	0

UH007

PERSONAL DATA - FRIDAY OCT 1924 RUN DATE 05 JUN 1985 1245

TRAINING HOSPITAL REPORT MONTH: JUN 1985 PAGE 3

* * * * * MONTHLY RECAP - INPATIENT OCCUPIED BED DAYS * * * * *

UCA INPATIENT OCCUPIED BED DAYS REPORT

CODE	TITLE	W07	W08	W11	ZAF	TOTAL
AAAA	INTERNAL MEDIC	0	0	0	0	437
AAAB	INFECTIOUS DIS	0	0	0	0	00
AAAC	ALLERGY	0	0	0	0	13
AABA	CARDIOLOGY	0	0	0	0	13
AADA	DERMATOLOGY	0	0	0	0	22
AAGA	HEMATOLOGY	0	0	0	0	14
AAKA	ONCOLOGY	0	0	0	0	14
ABAA	GENERAL SURGER	0	0	0	0	31
ABDA	NEUROSURGERY	0	0	0	0	14
ABFA	ORAL SURGERY	0	0	0	0	14
ACBA	LABOR/DELIVERY	0	0	0	0	32
ADBA	NURSERY	0	0	0	0	92
AEAA	ORTHOPEDICS	0	0	0	0	2
TOTAL		0	0	0	0	728

A-2-78

WARD NURSING REPORT

a. Definition. The Ward Nursing Report alphabetically lists all inpatients currently assigned to each ward, by ward. It gives demographic and admission data on each patient, and includes a summary of bed availability data for each ward. The data on this report reflects the hospital census at the date and time the report is run.

This report is usually printed daily, and is distributed as determined by the nursing supervisory staff. It is used to provide information and validation of hospital census and bed use data.

b. Format. The header for this report contains the standard data; the ward ID is included in the report title. The body of the report is presented in table form. Data is sorted by ward and, within ward, by patient name. Data is presented for no more than one ward per page.

c. Content. This report consists of a page of data for each ward, and up to three lines of data on each patient on the ward. The last page of the report is the Bed Summary by Ward, which contains data described in the Data Chart on the following page.

(1) PATIENT NAME.

(2) REG NO. Patient's register number.

(3) ATTEND PHYS. Name of the patient's attending physician. Table 1004.

(4) DAYS THIS MTF. Number of bed days this patient has accumulated during this inpatient episode.

(5) SSN.

(6) FMP. Patient's family member prefix. Table 1012.

(7) DOB. Patient's date of birth.

(8) ADMIT DIAG. Text of the diagnosis made on this patient at admission.

(9) ADMISSION REMARKS. Free text about the admission that was entered on the Admission Screen.

DATA CHART - WARD NURSING REPORT

(10) CAT. Code for the patient's patient category. Table 1002.

(11) RANK. Patient's rank if active duty. Table 1006.

(12) CLN SVC. Code for patient's clinical service assignment. Table 2005.

DATA CHART - WARD NURSING REPORT

(1) WARD. The ID of each MTF ward.

(2) BEDS IN WARD. The number of beds assigned to the ward.

(3) PATIENTS IN WARD. The number of patients occupying beds on the ward.

(4) BLOCKED BEDS. The number of beds on the ward that are either occupied by patients or otherwise unavailable.

(5) PREADMITS IN WARD. The number of preadmits assigned to the ward.

(6) BEDS AVAILABLE. The number of currently available beds on the ward.

(7) TOTAL. The bottom line on this page shows totals for fields (2) through (6), i.e., the total number of beds assigned for all wards, the total number of patients and blocked beds, preadmits, and available beds in the MTF.

DATA CHART - WARD NURSING REPORT, BED SUMMARY BY WARD

* * * * * WARD NURSING REPORT FOR 4E * * * * *

PATIENT NAME REG NO ATTEND PHYS DAYS THIS MTF	SSN ADMIT DIAG ADMISSION REMARKS	FMP	DOB	CAT	RANK	CLN SVC
BELLAMY,LAURA 0006483 JOHNS 1	290-12-1921 NORML PRIMIGRAVIDA	30	19 AUG 1952	N41		ACB
FRANKLIN,SANDRA 0006479 JONESB 1	342-81-9384 NORML PRIMIGRAVIDA	30	09 JUL 1954	N41		ACB

WARD NURSING REPORT

TEST NAVY MTF

PERSONAL DATA - PRIVACY ACT 1974 RUN DATE 31 AUG 1985 1824
PAGE 1

* * * * * BED SUMMARY BY WARD * * * * *

WARD	BEDS IN WARD	PATIENTS IN WARD	BLOCKED BEDS IN WARD	PREADMITS IN WARD	BEDS AVAILABLE
1X	5	0	3	0	2
23E	7	1	2	0	4
4E	10	2	3	0	5
4I	0	0	0	0	0
4S	10	6	0	0	4
5E	0	0	0	0	0
5S	10	1	0	0	9
5T	5	1	0	0	4
5U	5	1	0	0	4
6S	0	0	0	0	0
6W	0	0	0	0	0
IC	0	0	0	0	0
TOTAL	52	12	8	0	32

WARD NURSING REPORT, BED SUMMARY BY WARD

Appendix B

SYSTEM MANAGEMENT INPUTS AND OUTPUTS

Part 1. SYSTEM MANAGEMENT INPUTS (SCREENS)

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Part 1. SYSTEM MANAGEMENT INPUTS (SCREENS)

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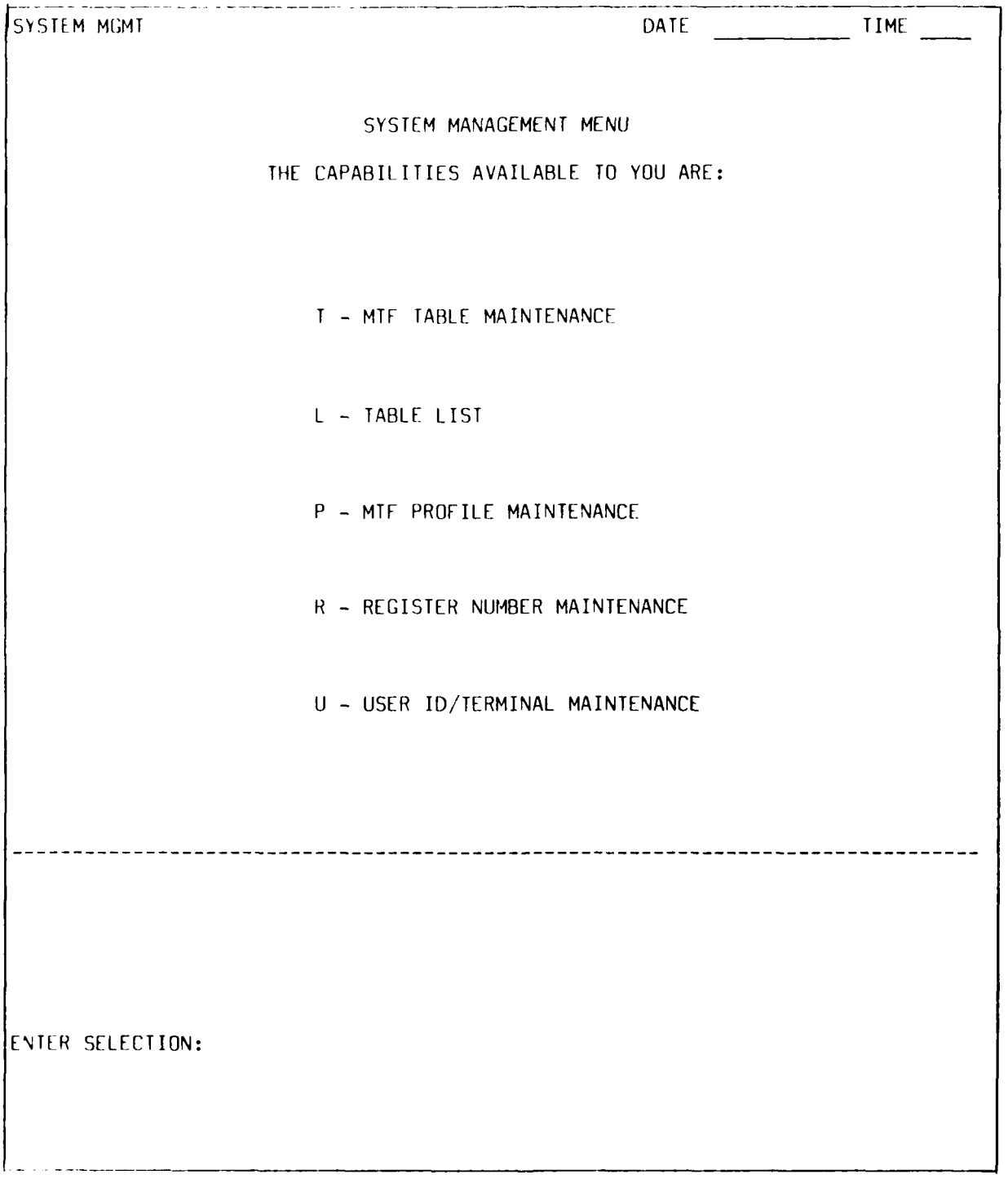
INTRODUCTION TO PART 1

Part 1 of this Appendix contains examples of screens used by the System Management function of AQCESS. Screens are accompanied by Data Charts which describe their data fields and give the number of the table where possible entries can be found. For fields where you can enter data, the Data Chart gives the number of characters that can be entered and indicates which fields are required to have data in them. A Data Chart follows each screen, except for menu screens and any screens that do not contain data fields.



SYSTEM MANAGEMENT MENU SCREEN

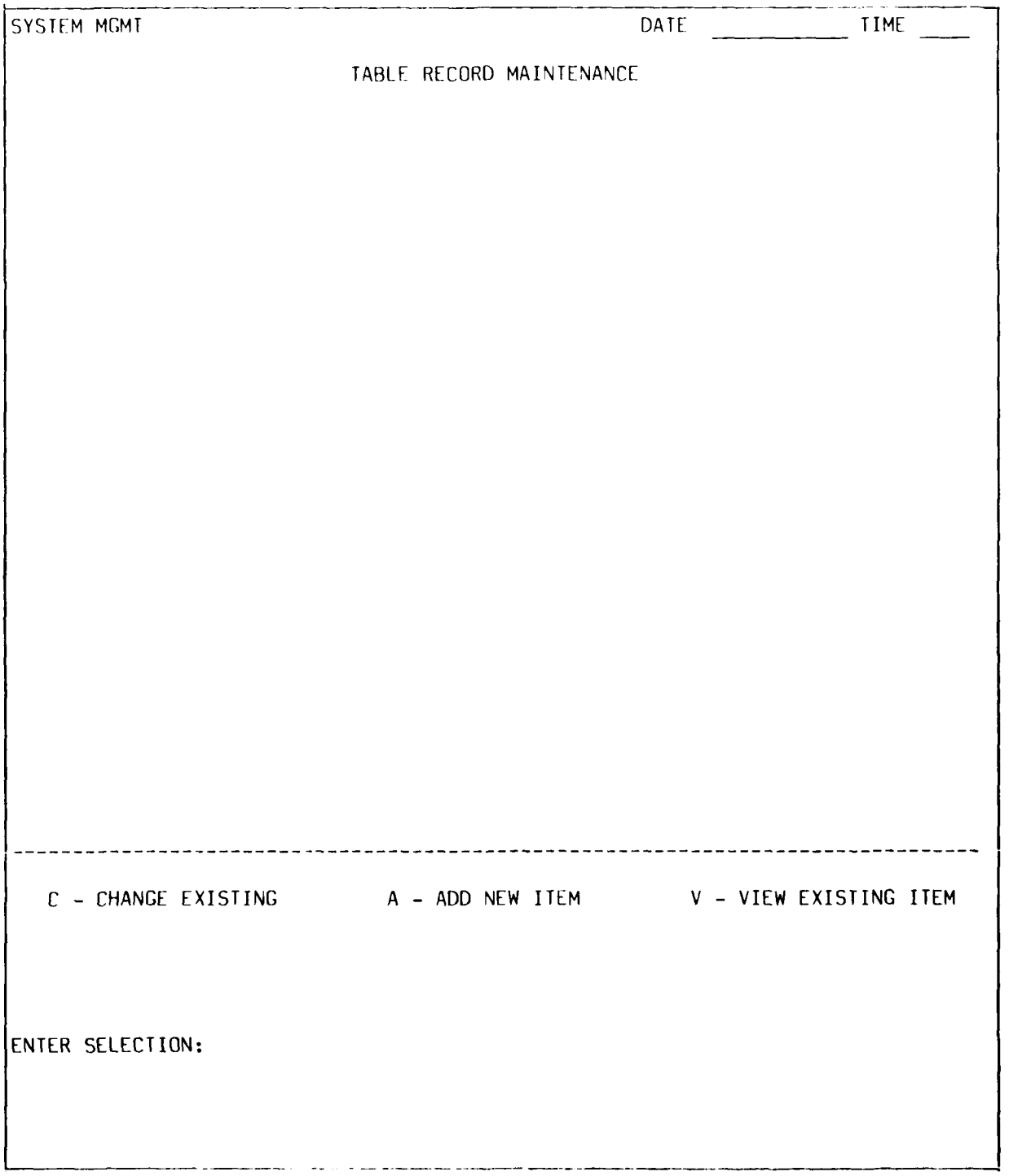


TABLE MAINTENANCE SCREEN

UH007

SYSTEM MGMT DATE _____ TIME ____

TABLE RECORD MAINTENANCE

TABLE ID **1004** TITLE **PRIM CARE PROVIDER (table)**

PRIM CARE PROVIDER CODE _____

DOCTOR NAME _____

SSN _____

DATE ASSIGNED TO MTF _____

SPECIALTY _____

AF ID CODE _____

DELETE DATE _____

C - CHANGE EXISTING A - ADD NEW ITEM V - VIEW EXISTING ITEM

ENTER SELECTION:

TABLE MAINTENANCE SCREEN, ADDING AN ITEM

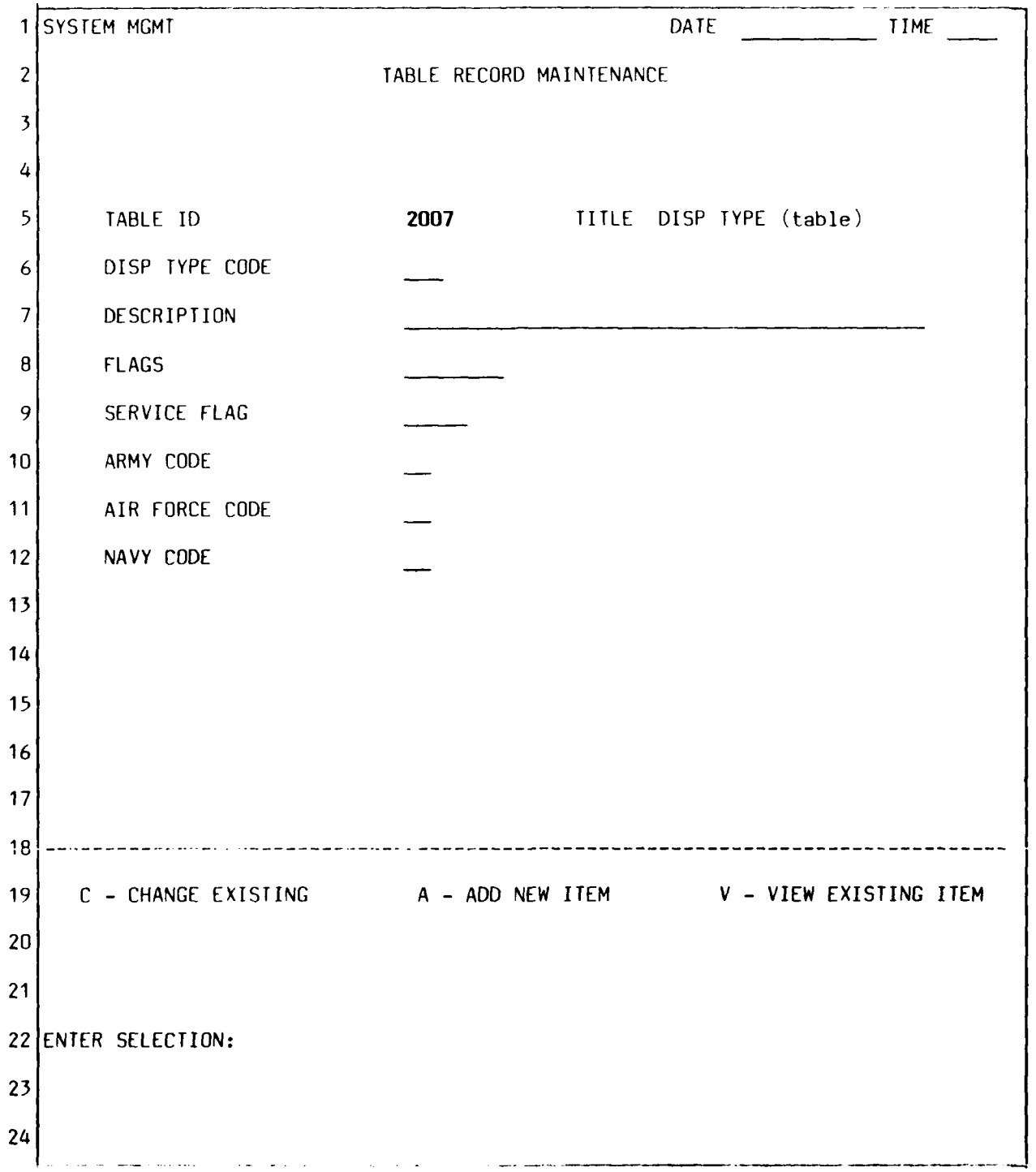


TABLE MAINTENANCE SCREEN, VIEWING AN EXISTING ITEM

(1) TABLE ID. The ID number of the table containing the item you want to view or change, or the table to which you want to add an item.

(2) TITLE. The name of the table whose ID number you entered in the previous field. Defaulted by system when table ID is entered.

(3) CODE. The code of the table item you want to view, change, or add.

(4) DESCRIPTION. Text defining the code. Defaulted by system.

The remaining fields displayed on this screen will vary, depending on the table. If you are changing or adding a table item, the parameters that apply to that table will be displayed. If you are viewing an existing item, the information displayed will also vary depending on the table, and may include fields such as the following:

(5) FLAGS. The numerical designations of the parameters set for this item. The meanings of these numbers is not displayed.

(6) SERVICE FLAG. The code for the military departments that use this table item.

(7) ARMY CODE. If this item is used by the Army, this field contains the code for this item that appears on reports to Army higher commands.

(8) AIR FORCE CODE. If this item is used by the Air Force, this field contains the code for this item that appears on reports to Air Force higher commands.

(9) NAVY CODE. If this item is used by the Navy, this field contains the code for this item that appears on reports to Navy higher commands.

DATA CHART - TABLE MAINTENANCE SCREEN

```
SYSTEM MGMT                                          DATE _____ TIME ____

                              TABLE LIST MENU

TABLE                                    TABLE
 NO  ---------- TITLE ----------          NO  ---------- TITLE ----------

 1000  RELIGION CODE                     1019  TERMINAL CAPABILITIES
 1002  PATIENT CATEGORY                  1020  FUNCTION TABLE
 1004  PRIMARY CARE PROVIDER             1021  PRODUCT DEVICE
 1005  MTF (MEDICAL TREATMENT FAC)       1023  BRANCH OF SERVICE
 1006  RANK CODE                         1024  RANK CODE
 1012  FMP (FAMILY MEMBER PREFIX)        1025  ZIP CODE TABLE
 1013  UNIT/ID SHIP                      1028  CAPABILITY PROFILES
 1014  FLYING STATUS                     1029  MILITARY SPECIALTY
 1015  STATE/COUNTRY CODES               2001  SOURCE OF ADMISSION
 1016  COMMAND INTEREST                  2002  ABSENT STATUS

--------------------------------------------------------------------------------

  S - SELECT TABLE NUMBER TO PRINT          P - VIEW PREVIOUS PAGE
  A - PRINT ALL TABLES                      N - VIEW NEXT PAGE

ENTER SELECTION:
```

TABLE LIST SCREEN

(1) TABLE NO. The ID number of the table. When selecting a table by number, enter this number in the selection field. For display only.

(2) TITLE. The name of the table. For display only.

DATA CHART - TABLE LIST SCREEN

```
SYSTEM MGMT                                                DATE ___________ TIME ____

                          MTF PROFILE MAINTENANCE


MTF CODE ____                MTF NAME ___________________________

SERVICE (A,F,N) _            TRAINING FLAG (Y/N) _     TRAINING DATE ___________

SOFTWARE VERSION NO ____     INVALID ATTEMPTS BEFORE LOCKOUT ___


                      ---------- PAD PARAMETERS ----------


AUTO REGISTER NUMBER (Y/N) _            INDEX CARDS (# PER SET) __  WAR (Y/N) _

PAD BLDG/ROOM DESIGNATION _________

MTF ADDRESS: CITY ___________________________ STATE __  ZIP CODE __________

PAD SIGNATURE BLOCK: LINE 1 ____________________________

                     LINE 2 ____________________________

                     LINE 3 ____________________________

PAD OFFICE SYMBOL ____________


-------------------------------------------------------------------------------

  1 - CR PARAMETERS       2 - QA PARAMETERS       3 - RETURN TO PAD PARAMETERS



ENTER SELECTION:
```

MTF PROFILE MAINTENANCE SCREEN, PAD PARAMETERS SEGMENT

(1) MTF CODE. 5 characters. Table 1005.

(2) MTF NAME. 20 characters.

(3) SERVICE (A,F,N). This MTF's military department. 1 character. For display only.

(4) TRAINING FLAG (Y/N). "Y" in this field indicates that this is the profile record for the training data base. For display only.

(5) TRAINING DATE. The override system date being used by the training data base. 11 characters.

(6) SOFTWARE VERSION NO. Number of the version of the AQCESS software being used at this MTF. 4 characters. For display only.

(7) INVALID ATTEMPTS BEFORE LOCKOUT. The number of times in succession that an invalid user ID/password combination can be entered before the terminal or the user ID locks. 2 digits.

PAD PARAMETERS SEGMENT

(1) AUTO REGISTER NUMBER (Y/N). "Y" indicates the Admission function assigns register numbers automatically to new records; "N" indicates that register numbers are entered manually by system users.

(2) INDEX CARDS (# PER SET). The number of 3X5 Cards or 5x8 Cards in each set requested in Admission or Transfer. 2 digits.

(3) WAR (Y/N). Indicates whether a state of war exists.

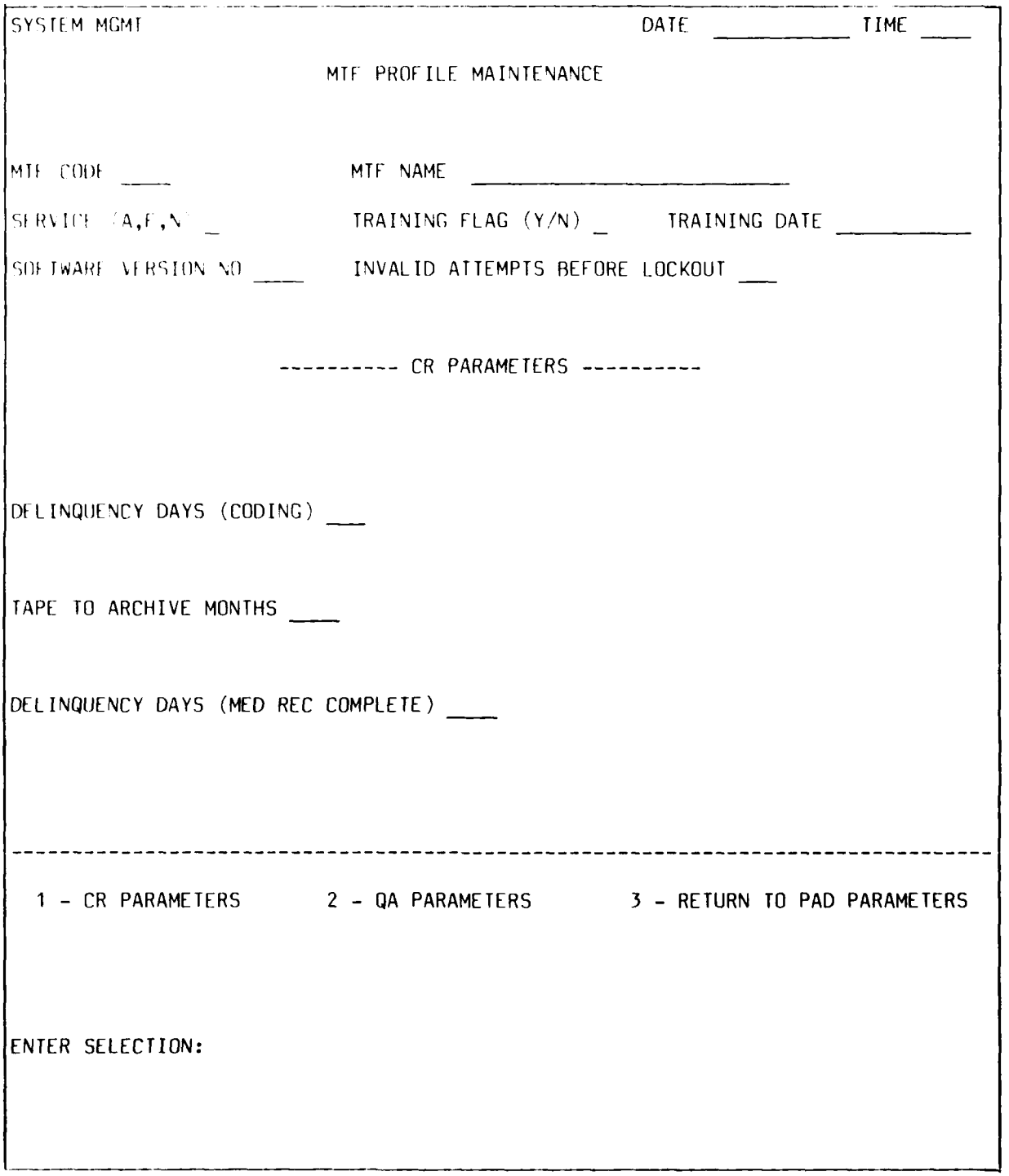
(4) PAD BLDG/ROOM DESIGNATION. Number of the building or the room in which the Patient Administration main office is located. 20 characters.

(5) MTF ADDRESS: CITY, STATE, and ZIP CODE.

(6) PAD SIGNATURE BLOCK: LINE 1, LINE 2, and LINE 3. The name and address of the Patient Administration official, or other information, which appears on reports. Up to 26 characters on each line.

(7) PAD OFFICE SYMBOL. PAD office symbol that prints on correspondence. 9 characters.

DATA CHART - MTF PROFILE MAINTENANCE SCREEN, PAD PARAMETERS SEGMENT



MTF PROFILE MAINTENANCE, CR PARAMETERS SEGMENT

(1) DELINQUENCY DAYS (CODING). Number of days after disposition by which a record must be completely processed by Clinical Records for reporting to higher commands or be considered delinquent. 2 digits.

(2) TAPE TO ARCHIVE MONTHS. Number of months before a completely processed record should be archived. 2 digits.

(3) DELINQUENCY DAYS (MED REC COMPLETE). Number of days after the start of Clinical Records processing by which the chart must be complete or be considered delinquent, which will cause a delinquency to be posted to the provider profile. 2 digits.

DATA CHART - MTF PROFILE MAINTENANCE, CR PARAMETERS SEGMENT

```
SYSTEM MGMT                                          DATE ___________ TIME ____

                         MTF PROFILE MAINTENANCE

MTF CODE ____              MTF NAME ____________________________

SERVICE (A,F,N) _          TRAINING FLAG (Y/N) _     TRAINING DATE ___________

SOFTWARE VERSION NO ____   INVALID ATTEMPTS BEFORE LOCKOUT ___

                    ---------- QA PARAMETERS ----------

DELINQUENCY DAYS FOR INPATIENT CHECKLIST __

AUTO ER LOG NO (Y/N) _

-----------------------------------------------------------------------------

  1 - CR PARAMETERS       2 - QA PARAMETERS       3 - RETURN TO PAD PARAMETERS

ENTER SELECTION:
```

MTF PROFILE MAINTENANCE SCREEN, QA PARAMETERS

(1) DAYS TO DELINQUENCY FOR CHECKLIST. Number of days after disposition by which an incomplete Occurrence Screening Checklist is considered delinquent. 2 digits.

(2) AUTO ER LOG NO (Y/N). "Y" indicates that log numbers are assigned automatically by the system to Emergency Room episodes. "N" indicates that they are assigned manually by the user.

DATA CHART - MTF PROFILE MAINTENANCE, QA PARAMETERS SEGMENT

SYSTEM MGMT DATE _____ TIME ____

REGISTER NUMBER MAINTENANCE

BLOCK NO	BEGINNING NUMBER	ENDING NUMBER	QUANTITY REQUESTED	QUANTITY REMAINING		
					_____	
1	_____	_____		____	_____	_____
					_____	_____
2	_____	_____		____	_____	_____
					_____	_____
3	_____	_____		____	_____	_____
					_____	_____
4	_____	_____		____	_____	_____
					_____	_____
5	_____	_____		____	_____	_____
					_____	_____

NEXT SEQUENTIAL REGISTER NUMBER _____

B# - RESERVE BLOCK # R# - RELEASE BLOCK # C - RETURN TO CANCEL POOL

V# - VIEW USED BLOCKS N - VIEW NEXT PAGE

ENTER SELECTION:

REGISTER NUMBER MAINTENANCE SCREEN

(1) BLOCK NO. The number identifying the block to be reserved or released.

(2) BEGINNING NUMBER. The first register number in the block. Calculated by the system from the number in the NEXT SEQUENTIAL REGISTER NUMBER field. Up to 7 characters.

(3) ENDING NUMBER. The last register number in the block. Calculated by the system by adding the QUANTITY REQUESTED to the BEGINNING NUMBER. Up to 7 characters.

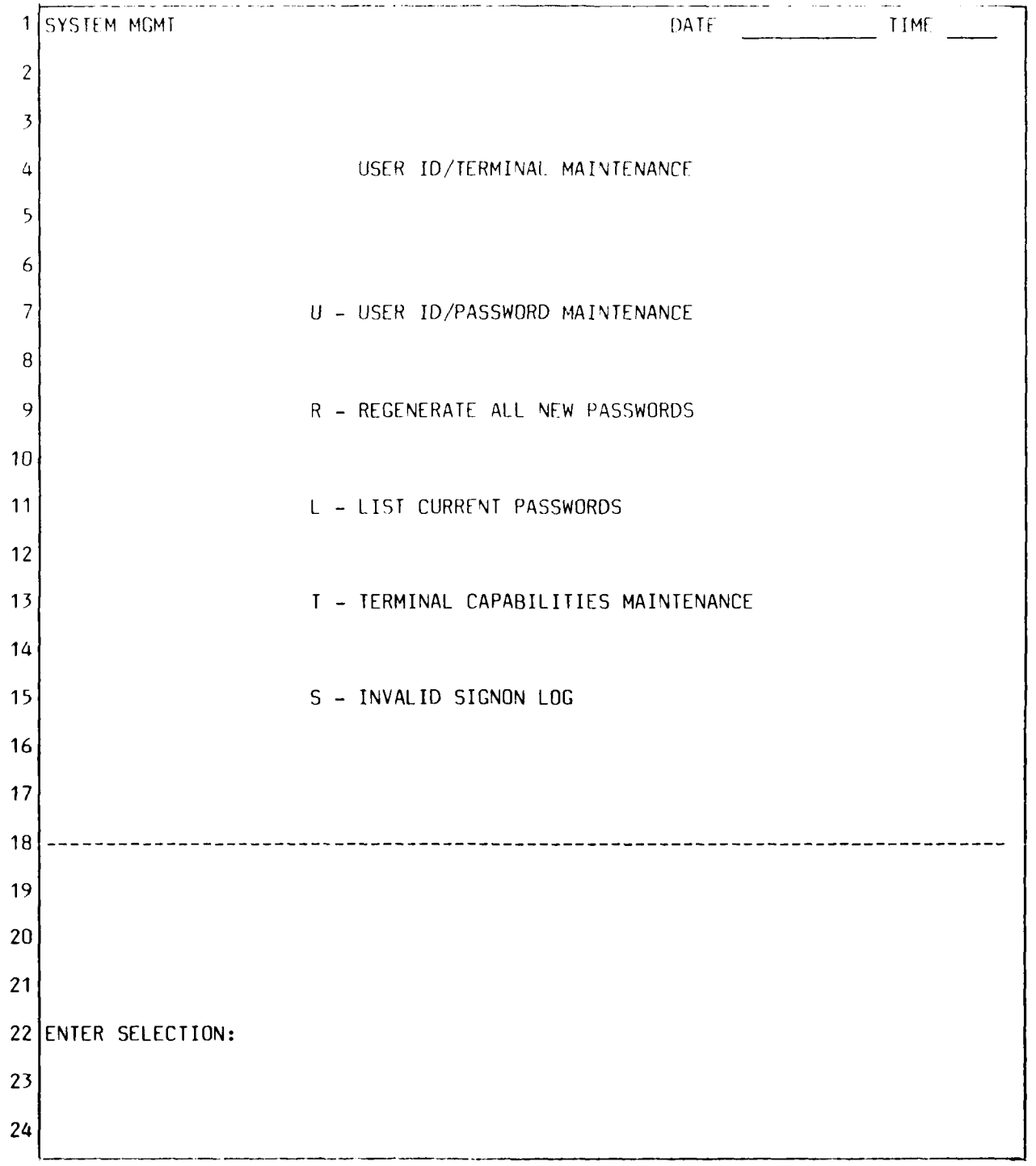
(4) QUANTITY REQUESTED. The number of register numbers that the system manager wants to reserve. Up to 3 characters.

(5) QUANTITY REMAINING. The number of register numbers in the reserved block that have not yet been assigned manually. Calculated by the system. Up to 4 characters.

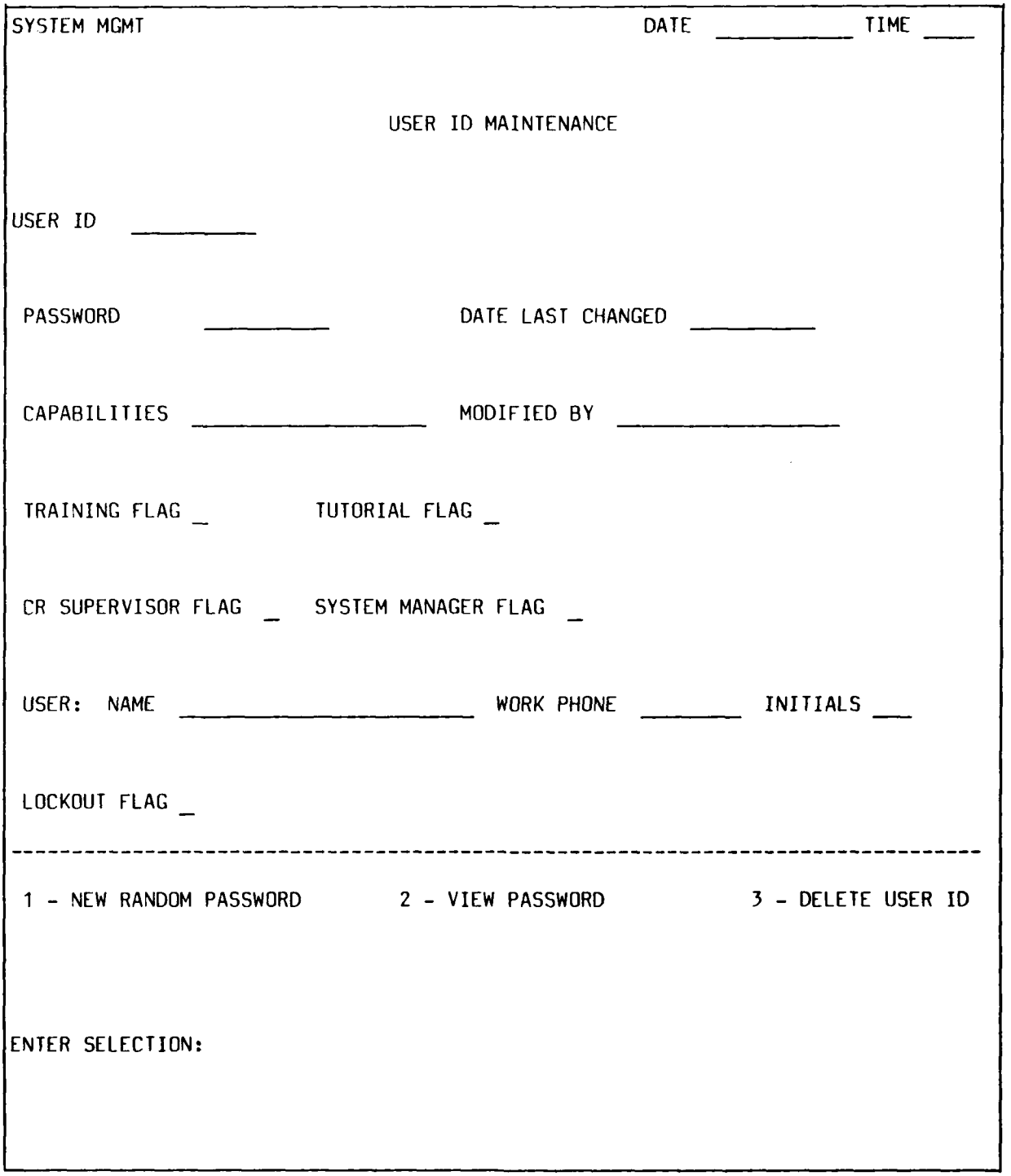
(6) CANCEL POOL. If a block of register numbers that has been reserved is released, to be assigned automatically, any numbers in that block that were not used will go into the cancel pool. The cancel pool also contains any number applied to an admission that was later cancelled. The cancel pool is displayed on the right side of the screen; it can display up to 20 register numbers per page.

(7) NEXT SEQUENTIAL REGISTER NUMBER. The next register number to be assigned to a record. Calculated by the system. Up to 7 characters.

DATA CHART - REGISTER NUMBER MAINTENANCE SCREEN



USER ID/TERMINAL MAINTENANCE MENU SCREEN



USER ID MAINTENANCE SCREEN

(1) USER ID. Up to 10 characters.

(2) PASSWORD is displayed if you select option 2 on this screen or create a new user ID and password. For a new user ID you can either enter a password, or leave this field blank and a randomly generated password will be assigned and displayed in this field. Up to 6 characters.

(3) DATE LAST CHANGED. Date when the password was last changed. 11 characters. For display only.

(4) CAPABILITIES. The AQCESS functions allowed to this user ID/password are listed in this field. Each function is represented by the letter or number to the left of it on the User Entry Menu. You can enter a string of letters to authorize capabilities for this user ID. Or you can enter a profile code for a type of user (Table 1028), and the functions allowed to that type of user will be displayed in this field. Up to 20 characters.

(5) MODIFIED BY. To modify the user's capabilities without retyping the entire string, enter + or - and the letter of the function to be added or removed. Up to 20 characters.

(6) TRAINING FLAG. A "Y" in this field indicates that the user ID gives access only to the training data base.

(7) TUTORIAL FLAG. A "Y" in this field indicates that the user can access the tutorial lessons, and can access the system in tutorial mode, which means Super Help messages and expanded error explanations are displayed automatically.

(8) CR SUPERVISOR FLAG. A "Y" in this field indicates that the user is authorized as the Clinical Records supervisor.

(9) SYSTEM MANAGER FLAG. A "Y" in this field indicates that the user is authorized as the System Manager.

(10) USER: NAME. Name of the user who has this user ID/password. Up to 27 characters. **Required when entering a new user ID/password.**

(11) WORK PHONE of this user. 8 characters.

(12) INITIALS of this user. Used to trace entries and updates of records. Up to 3 characters. **Required when entering a new user ID/password.**

(13) LOCKOUT FLAG. A "1" in this field indicates that this user is locked out of the system. "0" means that the user is able to use his or her assigned functions. You use this field to lock or unlock a user ID.

DATA CHART - USER ID MAINTENANCE SCREEN

```
SYSTEM MGMT                                          DATE ___________ TIME ____

                          TERMINAL ID MAINTENANCE

TERM ID ___

 CAPABILITIES ________________   MODIFIED BY ________________

 DEFAULT PRINTER ___

 LOCKOUT FLAG _

-----------------------------------------------------------------------------

ENTER SELECTION:
```

TERMINAL ID MAINTENANCE SCREEN

(1) TERM ID. ID number of the terminal. Up to 3 characters.

(2) CAPABILITIES. The AQCESS functions available to users at this terminal. You can enter a string of letters indicating the capabilities allowed at this terminal, or enter the profile code for a type of user (Table 1028), and the capabilities authorized for that type of user will appear in this field. Up to 20 characters.

(3) MODIFIED BY. To add to or delete the functions available from this terminal, the user enters + or - and the letter of the function to be added or deleted. Up to 20 characters.

(4) DEFAULT PRINTER. The printer that all screen print requests from this terminal will go to. Up to 3 characters.

(5) LOCKOUT FLAG. "1" in this field means that the terminal is locked. "0" means that it is functioning normally. You use this field to lock or unlock a terminal.

DATA CHART - TERMINAL ID MAINTENANCE SCREEN

Part 2. SYSTEM MANAGEMENT OUTPUTS (REPORTS)

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Part 2. SYSTEM MANAGEMENT OUTPUTS (REPORTS)

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INTRODUCTION TO PART 2

This Part lists the System Management reports. Their descriptions are organized as follows:

a. Definition - a brief description of the report or product, its purpose or function, frequency of production, distribution, and utilization.

   Both of the System Management reports are requested by the System Manager through the System Management function, from options listed on the User ID/Terminal Maintenance Menu Screen. When either report is selected, a Run-Time Information Screen is displayed, on which the System Manager specifies the time period of the report.

b. Format - the organization of the contents of the output, and any header or trailer data it might include.

c. Content - a Data Chart describing each data element on the output.

d. Example - a sample of each output.

INVALID SIGN-ON LOG

a. Definition. This report gives information about any incorrect entry of user IDs and passwords. On the Run-Time Information Screen for this report the System Manager can choose to have the current list of incorrect sign-ons erased after the current report is produced, in addition to specifying the time period of the report.

The Invalid Sign-On Log is produced on request and distributed to the System Manager and the Security Manager. It is used to monitor user ID and password use and to maintain the integrity of password security.

b. Format. The header of this report contains the MIF name, report title, page number, and the time period of the report.

The body of the report is arranged in table form, displaying the data described in the Data Chart below.

c. Content.

(1) DATE when the incorrect user ID or password was entered.

(2) TIME when the incorrect user ID or password was entered.

(3) USERCODE. The user ID entered.

(4) PASSWORD. The password entered.

(5) TERMINAL NO. The number of the terminal at which the incorrect sign-on was attempted.

(6) ATTEMPT COUNT. The number of consecutive invalid sign-on attempts represented by this user ID/password combination (e.g., this is the 4th consecutive attempt).

DATA CHART - INVALID SIGN-ON LOG

TEST NAVY MTF

USERCODE / PASSWORD ERROR LOG
FROM 20 AUG 1985 THRU 30 AUG 1985

DATE / TIME	USERCODE	PASSWORD	TERMINAL NO	ATTEMPT COUNT
20 AUG 1985 0829	ALLCLEK	ALL	76	1
20 AUG 1985 1614	AKLCLERK	ALL	76	1
21 AUG 1985 1102	ALLCLERK	LL	76	1
23 AUG 1985 1116	ALLCLERK	ALL	78	1
23 AUG 1985 1116	ALLCLERK	ALL	78	2
23 AUG 1985 1116	ALLCLERK	ALL	78	3
23 AUG 1985 1317	ALLCLEKR	ALL	76	1
23 AUG 1985 1357	ALLCLCLERK		76	1
23 AUG 1985 1533	ALCLELRK	ALL	76	1
23 AUG 1985 1744	ALLCLERK		71	1
26 AUG 1985 0950	ALLCLERK		76	1
26 AUG 1985 1334	ALLLCNER	ALL	76	1
26 AUG 1985 1634	ALLCLEKR	ALL	76	1
26 AUG 1985 1636	ALLCLERK		4	1
26 AUG 1985 1658	ALLCLERK		76	1
26 AUG 1985 1725	ALLCLERK		71	1
27 AUG 1985 1351	ALLCLERK		76	1
28 AUG 1985 1130	ALLCELRK	ALL	76	1
28 AUG 1985 1358	ALLCLERK	AL	76	1
28 AUG 1985 1410	ASLLCLERK	ALL	71	1
28 AUG 1985 1429	ALLCLERK	ALL;	78	1
28 AUG 1985 1536	ALLCLERK	AKL	76	1
28 AUG 1985 1543	ALLCLERK		76	1
29 AUG 1985 1030	ALLCLEKR	.A<	78	1
29 AUG 1985 1201	ALLCLERK	AL	71	1
29 AUG 1985 1211	ALLCLERK	AL	78	1
29 AUG 1985 1213	ALCLERLK	ALL	76	1

INVALID SIGN-ON LOG

LIST OF CURRENT PASSWORDS

a. Definition. This report lists the current user IDs and passwords, including the date when these were last changed and the privileges allowed to each ID-password combination. It is printed on request by the System Manager. This is a "secure" report--i.e., it can only be printed on the system console.

b. Format. The header of this report contains only the report title and report date. The body of the report is arranged in table form, containing the data described below.

c. Content.

(1) DATE LAST CHANGED. The date when this user ID/password was last changed.

(2) USERID. The user ID.

(3) NAME. Name of the user to whom this user ID and password are/were assigned.

(4) PASSWORD.

(5) CAPABILITIES. The AQCESS functions that the person with this user ID and password is authorized to use. Each function is represented by the letter or number that appears to the left of it on the User Entry Menu Screen.

(6) TRAIN. A "Y" in this field indicates that the person(s) with this user ID can only use the training data base.

(7) TUTOR. A "Y" in this field indicates that the person(s) with this user ID can access the tutorial lessons, and can access the system in tutorial mode, which means that Super Help messages and expanded error messages are displayed automatically on AQCESS screens.

(8) CR. A "Y" in this field means that the person(s) with this user ID can perform Clinical Records supervisory functions.

(9) SM. A "Y" in this field means that the person(s) with this user ID can perform System Manager functions.

(10) INITIALS. The initials of the person to whom this user ID/password combination is assigned. AQCESS tracks some user actions and will record these initials as the initials of the clerk performing those actions, if this user ID and password were used.

DATA CHART - LIST OF CURRENT PASSWORDS

LIST OF CURRENT PASSWORDS RUN DATE: 31 AUG 1985

DATE LAST CHANGED	USER ID NAME	PASSWORD	CAPABILITIES	FLAGS: TRAIN	TUTOR	CR	SM	INITIALS
12 FEB 1985	ALLCLERK ANYBODY	ALL	RADTHB1CSPEI2Q			Y	Y	HKK
13 FEB 1985	CCC	QDR526	RADTBCSH1PI			Y		MLS
13 FEB 1985	NEWCLERK	HRS352	RADTIHCPSB					LKJ
13 FEB 1985	HOLLY	TGC700	RADTIHPSB1					HKK
14 FEB 1985	TUTOR ALLUSERS	ME	RADTIHCPSB12	Y	Y			ALL
28 FEB 1985	TEST	TEST	RADTS1QPBHEI			Y	Y	LHJ
07 MAR 1985	QATEST	33	RADTH1EBICSQP			Y	Y	LHJ
20 MAR 1985	SUPCR CR SUPERVISOR	CR	HC2				Y	DKB
20 MAR 1985	SUPRADT RADT SUPERVISOR	RADT	1HBE			Y	Y	DKB
20 MAR 1985	SOMECLERK RADT CLERK	SOME	RADTH			Y	Y	DKB
20 MAR 1985	QACLERK QA PERSONNEL	QA	IQP			Y	Y	DKB
21 MAR 1985	PATIENTINQ PATIENT INQUIRER	INQ	I			Y	Y	
21 MAR 1985	CMCLERK CORRECTION CLERK	CM	E			Y	Y	
21 MAR 1985	DISPCLERK DISPOSITION CLERK	DSCHRG	D			Y	Y	DKB
21 MAR 1985	TRANSCLERK TRANSFER CLERK	TRANS	T			Y	Y	DKB
21 MAR 1985	INPNTHIST INPATIENT HISTORY PEOPLE	HIST	H			Y	Y	DKB
21 MAR 1985	CRCLERK CLINICAL RECORDS CLERK	CRREC	C			Y	Y	DKB
21 MAR 1985	CLINREC CLINICAL RECORDS PEOPLE	REPORT	2				Y	DKB
21 MAR 1985	SYSCLERK SYSTEM MANAGER	MANAGE	S					DKB

Appendix C

CLINICAL RECORDS INPUTS AND OUTPUTS

Part 1. CLINICAL RECORDS INPUTS (SCREENS)

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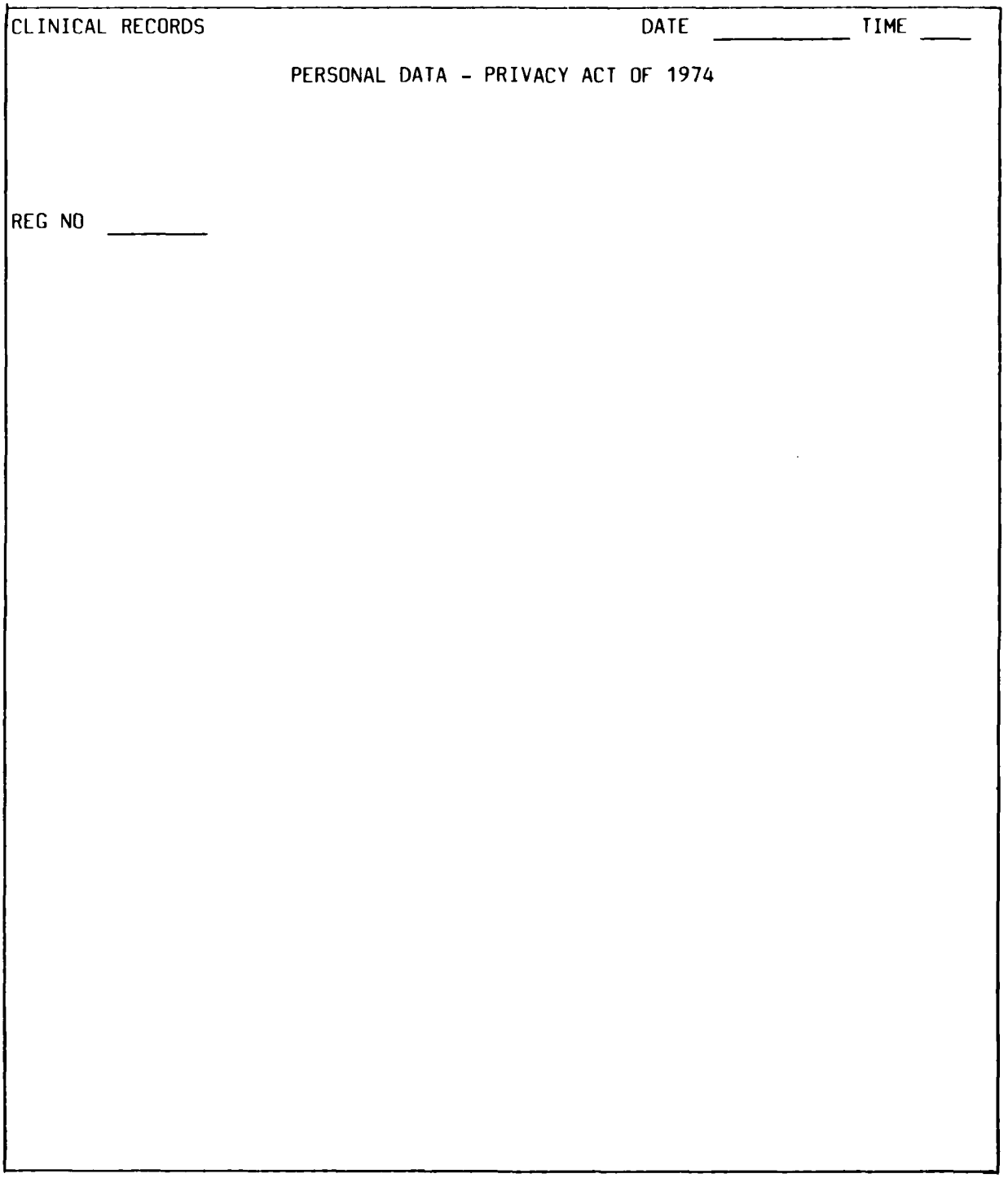
INTRODUCTION TO PART 1

Part 1 of this Appendix contains examples of screens used by the Clinical Records subsystem, which consists of the Clinical Records and Clinical Records Reports functions. Each screen that contains data fields is followed by a Data Chart describing those fields and giving the number of the table in which possible entries can be found. For fields where you can enter data, the description also includes the field length and indicates which fields are required to have data in them (** = required field). The symbols **A, F, N** mean that a field is used only the military department shown (it does not mean that the field is required).



CLINICAL RECORDS IDENTIFICATION (CRID) SCREEN

UH007

```
CLINICAL RECORDS                                    DATE ___________ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974

NAME ___________________________ SEX _ FMP __ SSN ___________ DOB ___________

ADMISSION:  REG NO ________ SOURCE ___ DATE/TIME _______________ WARD ____

DISPOSITION:  TYPE ____ DATE/TIME _______________ PHYSICIAN ORDERING ______

RECORD:  STATUS _ DATE/TIME MODIFIED _______________ CORRECTED _ CLERK ___

-----------------------------------------------------------------------------

1 - DIAGNOSIS   4 - TRANSFER HISTORY          7 - ADMIN TEXT    0 - CLERK ACTION

2 - PROCEDURES  5 - EPISODE DAYS BY DATE      8 - NON-PROC PHYS

3 - MISC        6 - EPISODE DAYS BY CLN SVC   9 - RECORD TRACKING

ENTER SELECTION:
```

CRID SCREEN, Showing Common Data and Sub-Menu

Each of the Clinical Records screens displays the data listed below. You cannot update any of these items.

(1) NAME of patient.

(2) SEX of patient.

(3) FMP. Patient's family member prefix. Table 1012.

(4) SSN. Social Security Number of patient's sponsor, or of patient if patient is a sponsor.

(5) DOB. Patient's date of birth.

(6) ADMISSION: REG NO. The 7- or 8-digit register number that identifies this inpatient episode.

(7) SOURCE. The source, or type, of the patient's admission. For Army, a 1-character code (e.g., 0 for direct admission). For Air Force and Navy, a code of up to 3 characters from Table 2001 (e.g., DIR for direct admission).

(8) DATE/TIME. Date and time that the patient was admitted for this inpatient episode.

(9) WARD. The patient's ward assignment at disposition.

(10) DISPOSITION: TYPE. Code indicating the patient's disposition status at the end of hospitalization. For Army, a 1-character code (e.g., A for DUTY). For Air Force and Navy, a 4-character code from Table 2007 (e.g., DUTY or HOME).

(11) DATE/TIME. Date and time when the patient left the hospital's care.

(12) PHYSICIAN ORDERING. Short name for the physician who authorized this disposition. Table 1004.

DATA CHART - COMMON PATIENT DATA

(13) RECORD: STATUS. A code indicating the stage of CR processing that this record is in. Actions taken by the CR clerk and supervisor on the Clerk Actions Screen change the record status. The code usually displayed here is "I" for "incomplete," meaning that CR processing has begun on this record but is not yet finished. The other record statuses are:

P = Patient has a projected disposition.
W = Record is waiting for supervisor's approval as complete.
A = Record has been approved by the supervisor for inclusion on reports to higher commands.
D = Record has been deleted from CR processing; it cannot be accessed in CR and does not appear on reports. (Record status can be set to D only after a record has been transmitted to higher commands.)
X = Record contains errors and has been rejected so that it can be corrected in CR.
R = Record has been released from CR control so that it can be accessed by an R/ADT function.

(14) DATE/TIME MODIFIED. The date when this record was last updated in CR.

(15) CORRECTED. Code indicating whether the record was sent to higher commands and then returned for correction. The record is marked as corrected so that when it is approved again and re-transmitted to higher commands, it will not be processed as a new record. A

(16) CLERK. The initials of the last clerk to update this record.

DATA CHART - COMMON PATIENT DATA

```
CLINICAL RECORDS                                    DATE ___________ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974

NAME ____________________________ SEX _  FMP __  SSN ___________ DOB ___________

ADMISSION:  REG NO ________  SOURCE ___  DATE/TIME ________________  WARD ____

DISPOSITION:  TYPE ____  DATE/TIME ________________  PHYSICIAN ORDERING ______

RECORD:  STATUS _  DATE/TIME MODIFIED ________________  CORRECTED _  CLERK ___


                        *** TOTAL DIAGNOSES __ ***

 1  ICD CODE: _____ _ _   CAUSE _ ___   OCC REL _   GROUP NBR __

    ____________________________________________________________

    ____________________________________________________________

 2  ICD CODE: _____ _ _   CAUSE _ ___   OCC REL _   GROUP NBR __

    ____________________________________________________________

    ____________________________________________________________

 3  ICD CODE: _____ _ _   CAUSE _ ___   OCC REL _   GROUP NBR __

    ____________________________________________________________

    ____________________________________________________________

-------------------------------------------------------------------------------

 N - NEXT PAGE       P - PREVIOUS PAGE       M - MOVE CODE     D - DELETE CODE



ENTER SELECTION:
```

DIAGNOSIS SCREEN

(1) TOTAL DIAGNOSES. The total number of diagnoses entered on this patient. Calculated by the system.

(2) (SEQUENCE NUMBER) of the diagnosis data set. Assigned by the system.

(3) ICD CODE. This field can contain:
- Code indicating the diagnosis, from the International Classification of Diseases. 5 digits. Table 9001.
- An asterisk/secondary/dagger code. 1 character. Table 4002.
- For Army, code indicating the place of diagnosis; for Navy, code indicating whether this condition existed prior to the patient's entry into the service ("EPTE"); for Air Force, the infection code. Table 4003.

(4) CAUSE. **N.** This field can contain:
- Code for class of trauma. Describes the injury. Table 2016. 1 character.
- Code indicating cause of the injury. Up to 3 characters. Table 2009.

(5) OCC REL. Code indicating whether this condition was occupationally related (Y/N). **N**

(6) GROUP NBR. Logical group number of the diagnosis, for printing on the ITRCS. 2 characters. **A**

(7) (TEXT). The description of the diagnosis that is associated with this ICD code. When the ICD code is entered, the first line of text defaults to the description from the ICD table. The description should be updated to reflect the provider's actual notes. When a CAUSE field is entered for a Navy patient, the text describing the cause of injury is displayed on second line of text. Up to 70 characters can be entered on each line.

DATA CHART - DIAGNOSIS SCREEN

```
1  CLINICAL RECORDS                                   DATE _____ TIME ____
2                        PERSONAL DATA - PRIVACY ACT OF 1974
3  NAME _____ SEX _ FMP __ SSN _____ DOB _____
4  ADMISSION:  REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____
5  DISPOSITION:  TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____
6  RECORD:  STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___
7
8                          *** TOTAL PROCEDURES __ ***
9   1  PROCD: ___ _ __ DATE _____-_____ PRVDR _____ _____ _____
10     _____
11     _____
12  2  PROCD: ___ _ __ DATE _____-_____ PRVDR _____ _____ _____
13     _____
14     _____
15  3  PROCD: ___ _ __ DATE _____-_____ PRVDR _____ _____ _____
16     _____
17     _____
18 ------------------------------------------------------------------------
19  N - NEXT PAGE      P - PREVIOUS PAGE      M - MOVE CODE      D - DELETE CODE
20
21
22 ENTER SELECTION:
23
24
```

PROCEDURE SCREEN

(1) TOTAL PROCEDURES. Total number of procedures entered for this episode. Calculated by the system.

(2) (SEQUENCE NUMBER) of the procedure data set. Assigned by the system.

(3) PROCD. This field can contain:
- Code indicating the procedure (i.e., operation) performed, from the International Classification of Procedures. 4 digits. Table 9002.
- Code indicating where the procedure was performed. 1 character. Table 4009.
- Code indicating the number of times this procedure was performed on this patient during the inpatient episode (1-99).

(4) DATE on which the procedure was performed. If this procedure was performed more than once, the dates of the first and last times can be entered. 11 characters in each date field. **Required for each procedure.**

(5) PRVDR. Short name of the provider who performed the procedure. Three providers can be entered. The first is the primary provider, second is the assistant provider, and third is a teaching or other assistant. Table 1004. **Required for each procedure performed in this MTF.**

(6) (TEXT). Description of the procedure. Defaulted to the description of the ICP code entered, but can be updated. Two lines allowed, with 64 characters in each.

DATA CHART - PROCEDURE SCREEN

```
1  CLINICAL RECORDS                                    DATE _____ TIME ____
2                        PERSONAL DATA - PRIVACY ACT OF 1974
3  NAME _____ SEX _ FMP __ SSN _____ DOB _____
4  ADMISSION:  REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____
5  DISPOSITION:  TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____
6  RECORD:  STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___
7                              *** MISCELLANEOUS ***
8  ATTEND/PRIMARY PROVIDER _____          TYPE CASE ___ AGE ___
9  ANESTHETIC RISK CODE _                 CAUSE DEATH/SEPARATION _
10 CC'S WHOLE BLOOD ____                  CC'S PACKED CELLS ____
11 TFR OUT:  MODE _      MTF _____        CIV HOSP _____
12 TRANSFER VA HOSPITAL/AUTOPSY _         DATE INITIAL PROCEDURE _____
13 CAUSE OF INJURY _ ___                  RESIDUAL DISABILITY ___
14 CAUSE OF INJURY DATA _____
15 _____
16 _____
17 CONVALESCENT LEAVE DAYS RECOMMENDED ___  PRESENTATION OF FETUS _ _ _ _
18 ----------
19
20
21
22 ENTER SELECTION:
23
24
```

MISCELLANEOUS SCREEN

(1) ATTEND/PRIMARY PROVIDER. Short name for the patient's primary health care provider. This is the responsible provider, who also signs the ITRCS or RIPT. Table 1004. Up to 6 characters. **

(2) TYPE CASE. Code indicating type of case. Table 2004. Defaults to type case entered in admission, but can be updated. 3 characters.

(3) AGE of patient. Calculated from date of birth. This field can only be updated if the patient is a newborn. For Army, Table 4010; for Air Force, Table 4011. Up to 3 characters.

(4) ANESTHETIC RISK CODE. The risk code assigned to this patient (a number between 1 and 5). You are encouraged to enter an anesthetic risk code if any procedure was performed on the patient, as this adds valuable information to some reports.

(5) CAUSE DEATH/SEPARATION. Code indicating the diagnosed condition, as entered on the CR Diagnosis Screen, that was the cause of the patient's death or separation from service. Also indicates separations caused by injury. Table 4001. 1 character.

(6) CC'S WHOLE BLOOD used during this inpatient episode. Up to 4 digits.

(7) CC'S PACKED CELLS used during this inpatient episode. Up to 4 digits.

(8) TFR OUT: MODE. Mode of transportation used if the patient transferred out of the hospital. 1 character. F

(9) MTF. Code of the MTF to which patient was transferred. Table 1005 or, for Army, a constructed code for non-Army MTFs. Defaulted to the MTF entered on the Disposition Screen but can be updated. Up to 6 characters. **Required for all patients who transfer out.**

(10) CIV HOSP. Name of the civilian hospital transferred to, if any. 27 characters.

(11) TRANSFER VA HOSPITAL/AUTOPSY. Indicates if patient transferred to a VA Hospital, or whether an autopsy was performed. 1 character. A

(12) DATE INITIAL PROCEDURE. Date when the first procedure was performed during this inpatient episode. 11 characters. N

(13) CAUSE OF INJURY. Contains:
- Class of trauma code. Table 2016. 1 character. F, N
- Cause of injury. Table 2009. 3 characters.

This field and field 15 default to the cause of injury code and text entered in Admission.

DATA CHART - MISCELLANEOUS SCREEN

(14) RESIDUAL DISABILITY. Code indicating the level of the patient's disability, if any. 3 characters. **A**

(15) CAUSE OF INJURY DATA. Description of the cause of injury. Up to 3 lines available for free text (58 characters on first line, 75 characters on each of the other two lines).

(16) CONVALESCENT LEAVE DAYS RECOMMENDED. Number of days of convalescent leave recommended, if any. 3 digits. **F, N**

(17) PRESENTATION OF FETUS. 2-character code describing presentation of the fetus. Up to 4 codes allowed, for multiple birth. Table 4005. **F**

DATA CHART - MISCELLANEOUS SCREEN

```
1  CLINICAL RECORDS                                        DATE _____ TIME ____
2                          PERSONAL DATA - PRIVACY ACT OF 1974
3  NAME _____ SEX _ FMP __ SSN _____ DOB _____
4  ADMISSION: REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____
5  DISPOSITION: TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____
6  RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___
7
8                              *** TRANSFER HISTORY ***
9       MTF  ADMISSION    DISPOSITION   BED   ABS   CONV  COOP  SUPP  OTH   MODE
10           DATE         DATE          DAYS  SICK  LV    CARE  CARE  DAYS
11    1  ____ _________ _________ ____ ____ ____ ____ ____ ____ _
12    2  ____ _________ _________ ____ ____ ____ ____ ____ ____ _
13    3  ____ _________ _________ ____ ____ ____ ____ ____ ____ _
14    4  ____ _________ _________ ____ ____ ____ ____ ____ ____ _
15    5  ____ _________ _________ ____ ____ ____ ____ ____ ____ _
16    6  ____ _________ _________ ____ ____ ____ ____ ____ ____ _
17    7  ____ _________ _________ ____ ____ ____ ____ ____ ____ _
18 ------------------------------------------------------------------------
19 N - NEXT PAGE          P - PREVIOUS PAGE          D - DELETE LINE
20
21
22 ENTER SELECTION:
23
24
```

TRANSFER HISTORY SCREEN

(1) (SEQUENCE NO.) of the transfer data. Assigned by system.

(2) MTF. Code of the MTF the patient was transferred from. On first line, this field defaults to the MTF code entered in Admission if patient was a transfer-in. Table 1005 or, for Army, a constructed code for non-Army MTFs. Army must also code the MTF for absent sick admission in this field, in which case no dates or other fields should contain data.

(3) ADMISSION DATE. Date of admission to the previous MTF. On first line, this field defaults to the initial admission date entered in Admission if the patient was a transfer-in.

(4) DISPOSITION DATE. Date of disposition from the previous MTF (i.e., the date when the patient left the specified MTF. **Required for transfer-in patients.**

For transfer-in patients, you must use the following days fields to enter the number of days the patient spent under the care of the previous MTF. The total of the number of days spent on each absent status must equal the number of days the patient spent at the previous MTF.

(5) BED DAYS. The total number of days that the patient spent on an absent status for which bed days are counted during the previous episode. Up to 4 digits.

(6) ABS SICK. The number of days that the patient spent with an absent status of "absent sick." Up to 4 digits.

(7) CONV LV. The number of days that the patient spent with an absent status of "convalescent leave." Up to 4 digits.

(8) COOP CARE. The number of days that the patient spent with an absent status of "cooperative care." Up to 4 digits.

(9) SUPP CARE. The number of days that the patient spent with an absent status of "supplemental care." Up to 4 digits.

(10) OTH DAYS. The number of days that the patient spent on another absent status for which bed days are not counted. Up to 4 digits.

(11) MODE. The patient's mode of transportation when being transferred out of the previous MTF. 1 character.

DATA CHART - TRANSFER HISTORY SCREEN

CLINICAL RECORDS DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ SEX _ FMP __ SSN _____ DOB _____

ADMISSION: REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____

DISPOSITION: TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____

RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___

*** EPISODE DAYS BY DATE ***

CLN SVC	ABS STATUS	DATE ASSIGNED	DAYS: TOTAL	BED	NON-BED
____	___	_____	____	____	____
____	___	_____	____	____	____
____	___	_____	____	____	____
____	___	_____	____	____	____
____	___	_____	____	____	____
____	___	_____	____	____	____
____	___	_____	____	____	____
			==========		
	TOTALS FOR THIS MTF		____	____	____

N - NEXT PAGE P - PREVIOUS PAGE

ENTER SELECTION:

EPISODE DAYS BY DATE SCREEN

CLINICAL RECORDS DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ SEX _ FMP __ SSN _____ DOB _____

ADMISSION: REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____

DISPOSITION: TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____

RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___

*** EPISODE DAYS BY CLINICAL SERVICE ***

CLN SVC	ABS STATUS	DATE ASSIGNED	DAYS:	TOTAL	BED	NON-BED
____	__	_____	_____	___	___	___
____	__	_____	_____	___	___	___
____	__	_____	_____	___	___	___
____	__	_____	_____	___	___	___
____	__	_____	_____	___	___	___
____	__	_____	_____	___	___	___
____	__	_____	_____	___	___	___
____	__	_____	_____	___	___	___
____	__	_____	_____	___	___	___

N - NEXT PAGE P - PREVIOUS PAGE

ENTER SELECTION:

EPISODE DAYS BY CLINICAL SERVICE SCREEN

All of the following data fields appear on both Episode Days Screens except DAYS, which is only used on the Episode Days by Clinical Service Screen. This data is calculated by the system; you cannot update it.

(1) CLN SVC. The patient's clinical service assignment. On the Episode Days by Date Screen, clinical service/absent status assignments are listed in chronological order.

(2) ABS STATUS. The patient's absent status.

(3) DATE ASSIGNED. Date of the clinical service/absent status assignment.

(4) DAYS. On the Episode Days by Clinical Service Screen, this column shows the total number of days the patient spent on this clinical service.

(5) TOTAL. The total number of days accumulated for this clinical service/absent status combination.

(5) BED. The number of days on this clinical service that the patient had a status for which bed days are counted. On the Episode Days by Clinical Service Screen, this column shows the total number of bed days for the clinical service.

(6) NON-BED. The number of days on this clinical service that the patient had an absent status for which non-bed days are counted. On the Episode Days by Clinical Service Screen, this column shows the total number of non-bed days for the clinical service.

(7) TOTALS FOR THIS MTF. This line displays the total number of days during the inpatient episode, and the total number of bed days and non-bed days accumulated.

DATA CHART - EPISODE DAYS SCREENS

CLINICAL RECORDS DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ SEX _ FMP __ SSN _____ DOB _____

ADMISSION: REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____

DISPOSITION: TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____

RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___

*** ADMINISTRATIVE DATA ***

SELECTED ADMINISTRATIVE DATA: _____

_____

_____

_____

_____

_____

_____

---

1 - FIRST PAGE 2 - SECOND PAGE

ENTER SELECTION:

ADMINISTRATIVE DATA SCREEN

(1) SELECTED ADMINISTRATIVE DATA. Free text for administrative remarks on this inpatient episode. Up to 49 characters available on the first line, and 76 characters available on each of the other 6 lines. 2 pages available.

DATA CHART - ADMINISTRATIVE DATA SCREEN

```
1  CLINICAL RECORDS                                   DATE _____ TIME ____
2                        PERSONAL DATA - PRIVACY ACT OF 1974
3  NAME _____ SEX _ FMP __ SSN _____ DOB _____
4  ADMISSION: REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____
5  DISPOSITION: TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____
6  RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___
7                        *** NON-PROCEDURAL PROVIDERS ***
8  PROVIDER _____      PROVIDER _____      PROVIDER _____
9  PROVIDER _____      PROVIDER _____      PROVIDER _____
10 PROVIDER _____      PROVIDER _____      PROVIDER _____
11 PROVIDER _____      PROVIDER _____      PROVIDER _____
12 PROVIDER _____      PROVIDER _____      PROVIDER _____
13 PROVIDER _____      PROVIDER _____      PROVIDER _____
14 PROVIDER _____      PROVIDER _____      PROVIDER _____
15 PROVIDER _____      PROVIDER _____      PROVIDER _____
16 PROVIDER _____      PROVIDER _____      PROVIDER _____
17 PROVIDER _____      PROVIDER _____      PROVIDER _____
18 ------------------------------------------------------------------------
19
20
21
22 ENTER SELECTION:
23
24
```

NON-PROCEDURAL PROVIDERS SCREEN

(1) PROVIDER. You can enter short names of up to 30 providers associated with this inpatient episode but not associated with any of the procedures performed during it. Up to 6 characters for each name. Table 1004.

DATA CHART - NON-PROCEDURAL PROVIDERS SCREEN

CLINICAL RECORDS DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ SEX _ FMP __ SSN _____ DOB _____

ADMISSION: REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____

DISPOSITION: TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____

RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___

** RECORD TRACKING **

STATUS _ START DATE: _____ SUSPENSE DATE: _____

	PROVIDER	MISSING SIG	DATE COMP	MISSING DICT	DATE COMP
HISTORY PHY:	_____	_	_____	_	_____
NARRATIVE:	_____	_	_____	_	_____
OP REPORT:	_____	_	_____	_	_____
DISC ORDER:	_____	_	_____	_	_____
DISC NOTE:	_____	_	_____	_	_____

NURSING WARD: ____/____/____

REMARKS: _____

_____

---

1 - OTHER MISSING SIGNATURES

ENTER SELECTION:

RECORD TRACKING SCREEN

(1) STATUS. 1-character code indicating whether the chart is complete, incomplete, checked out, or whether it is waiting for results. **

(2) START DATE. The date when Clinical Records processing was initiated on this record. Calculated by the system, but you can update it. 11 characters.

(3) SUSPENSE DATE. The date by which the record must be complete or it will be considered delinquent. Calculated by the system from the start date and the number of days until medical record delinquency (which is specified on the MTF Profile Screen in System Management).

This screen lists the following items that are tracked, if missing.

(4) HISTORY PHY. The history physical.

(5) NARRATIVE. The narrative summary.

(6) OP REPORT. A report on any procedures performed.

(7) DISC ORDER. The discharge order.

(8) DISC NOTE. Discharge notes.

For each missing item, data items 9 through 13 can be entered:

(9) PROVIDER. Short name of the provider responsible for this part of the record. Up to 6 characters. Table 1004.

(10) MISSING SIG. X in this field indicates that this part of the record is missing a signature.

(11) DATE COMP. Date on which the signature on this part of the record was subsequently received. 11 characters. (If you enter a date complete, you must also enter X in field 10.)

(12) MISSING DICT. X in this field indicates that dictation about this part of the record is missing.

(13) DATE COMP. Date on which the dictation for this part of the record was subsequently received. (You must have entered an X in field 12.)

(14) NURSING WARD. ID of the ward having missing information. IDs for up to 3 wards can be entered.

(15) REMARKS. 2 70-space lines available for remarks about the record.

DATA CHART - RECORD TRACKING SCREEN

```
1  CLINICAL RECORDS                                    DATE _____ TIME ____
2                        PERSONAL DATA - PRIVACY ACT OF 1974
3  NAME _____ SEX _ FMP __ SSN _____ DOB _____
4  ADMISSION:  REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____
5  DISPOSITION:  TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____
6  RECORD:  STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___
7
8  OTHER MISSING SIGNATURES:
9                    PROVIDER          DATE COMPLETE
10                   _____             _____
11                   _____             _____
12                   _____             _____
13                   _____             _____
14                   _____             _____
15                   _____             _____
16                   _____             _____
17                   _____             _____
18 ------------------------------------------------------------------------
19
20     1 - RETURN TO PRIMARY RECORD TRACKING SCREEN
21
22 ENTER SELECTION:
23
24
```

RECORD TRACKING MISSING SIGNATURE SCREEN

(1) PROVIDER. Short name of the provider whose signature is missing from the chart. Up to 6 characters. Table 1004. As many as 8 names can be entered.

(2) DATE COMPLETE. Date on which this provider's signature was subsequently received. 11 characters.

DATA CHART - OTHER MISSING SIGNATURES SCREEN

CLINICAL RECORDS DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ SEX _ FMP __ SSN _____ DOB _____

ADMISSION: REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____

DISPOSITION: TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____

RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___

CLERK:	SUPERVISOR:
P - PRINT DRAFT ITRCS/COVER SHEET	A - APPROVE
S - PRINT CODED EPISODE SUMMARY	D - DELETE
W - WAITING SUPERVISOR APPROVAL	O - OVERRIDE
R - RELEASE TO A & D	X - REJECT
	C - CLERK LIST

SELECT ACTION: _ SUPERVISOR USER CODE: _____ PASSWORD: _____

AUTHORIZED SIGNER FOR REPORT: ___

REASON FOR RELEASE: _____

ENTER SELECTION:

CLERK ACTIONS SCREEN

(1) SUPERVISOR USER CODE. The user code of the CR supervisor.

(2) PASSWORD. The password of the CR supervisor.

(3) AUTHORIZED SIGNER FOR REPORT. Table 4000.

(4) REASON FOR RELEASE. Free text.

DATA CHART - CLERK ACTIONS SCREEN

```
1  CLINICAL RECORDS                                    DATE _____ TIME ____
2                        PERSONAL DATA - PRIVACY ACT OF 1974
3  NAME _____ SEX _ FMP __ SSN ___-__-____ DOB _____
4  ADMISSION:  REG NO _____ SOURCE ___ DATE/TIME _____ WARD ____
5  DISPOSITION:  TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____
6  RECORD:  STATUS _ DATE/TIME MODIFIED _ _____ CORRECTED _ CLERK ___
7                        ** CLERK UPDATE LIST **
8      CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
9      CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
10     CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
11     CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
12     CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
13     CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
14     CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
15     CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
16     CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
17     CLERK: ___ DATE: _____ CLERK: ___ DATE: _____
18 ------------------------------------------------------------------------
19 1 - DIAGNOSIS   4 - TRANSFER HISTORY        7 - ADMIN TEXT   0 - CLERK ACTION
20 2 - PROCEDURES  5 - EPISODE DAYS BY DATE    8 - NON-PROC PHYS
21 3 - MISC        6 - EPISODE DAYS BY CLN SVC 9 - RECORD TRACKING
22 ENTER SELECTION:
23
24
```

CLERK LIST SCREEN

Data on this screen is defaulted by the system and cannot be updated.

(1) CLERK. Initials of the clerk who updated this record. Up to 20 can be displayed.

(2) DATE on which this clerk updated the record. In chronological order.

DATA CHART - CLERK LIST SCREEN

```
CR REPORTS                                        DATE _____ TIME ___

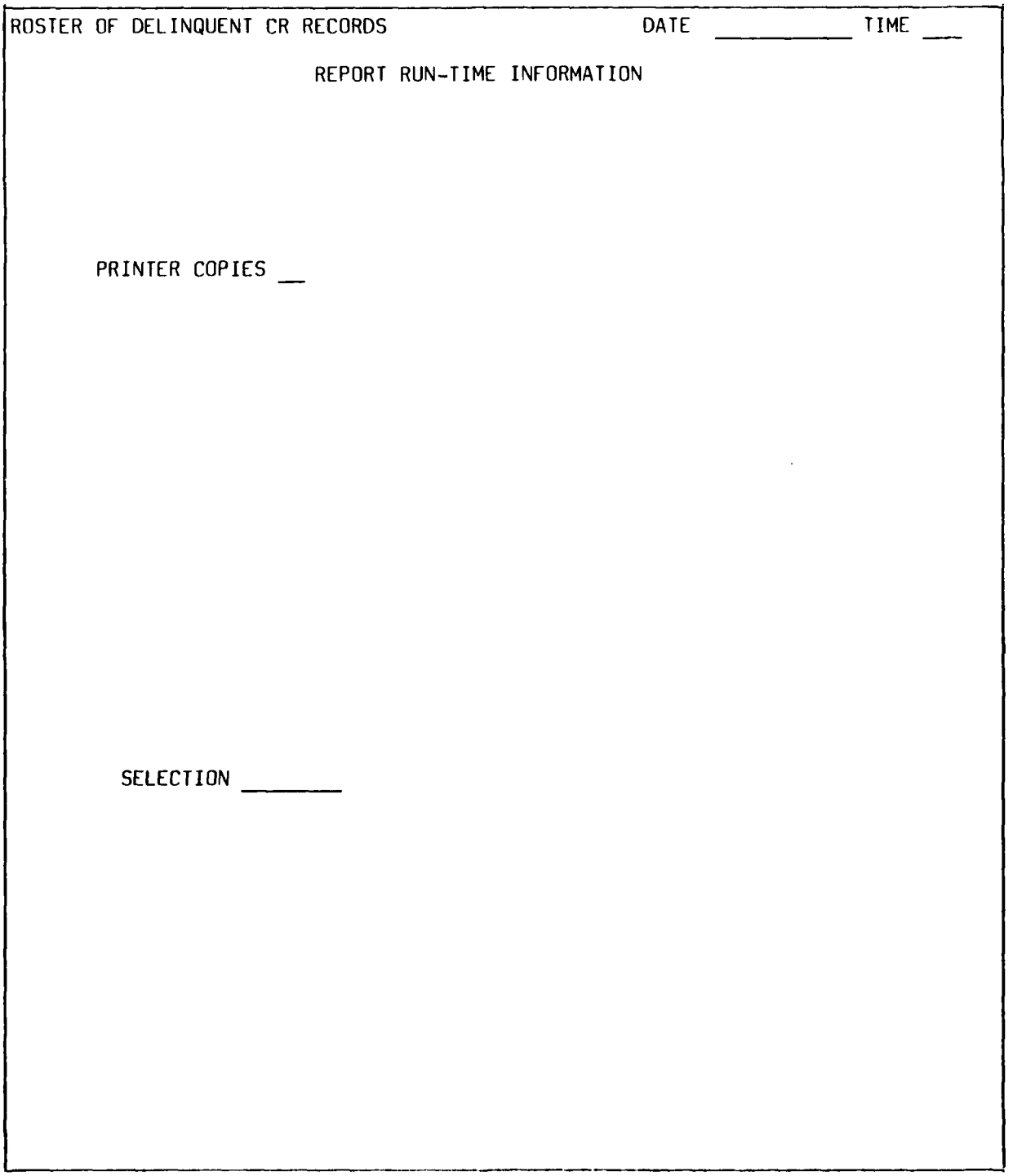
 NUMBER   REPORT TITLE
-------------------------------------------------------------------------------

   1 - ROSTER OF DELINQUENT RECORDS
   2 - CR END OF MONTH SUMMARY
   3 - CLINICAL RECORDS RETURNED TO A&D
   4 - INCOMPLETE INPNT MED RECORDS BY PROVIDER

-------------------------------------------------------------------------------
 N - ALL NIGHTLY REPORTS (1-1)          M - ALL MONTHLY REPORTS (2-2)

    ENTER REPORT NUMBER(S): _____
```

CR REPORTS - SELECTION SCREEN
(Reports listed may vary)



CR REPORTS - RUN-TIME INFORMATION SCREEN FOR THE ROSTER OF DELINQUENT RECORDS

The Run-Time Information Screen displays different fields, or parameters, for each report. All screens contain a PRINTER COPIES field; some allow you to specify the report period, which is period of time for which you want data. You must enter a date in any fields that ask you to specify the report period.

(1) PERIOD START. First day of the report period. **

(2) PERIOD END. Last day of the report period. **

(3) PRINTER COPIES. Number of copies you want run. Entries you can make in this field are listed below. (Some reports cannot be displayed at a terminal. If so, a message to that effect will be displayed at the top this screen.)

- If you leave this field blank, the report will be displayed at your terminal instead of being printed.
- If you enter R, the last report run will be displayed at your terminal.
- If you enter a number, that many copies of the report will be printed.
- If you enter R and a number (e.g., R3), the last report run will be printed as many times as you indicate.

The SELECTION field on this screen operates in the same way as the ENTER SELECTION field on any other screen. You can enter all or part of the parameter label to return to that field and update it.

DATA CHART - RUN-TIME INFORMATION SCREEN

Part 2. CLINICAL RECORDS OUTPUTS (REPORTS)

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INTRODUCTION TO PART 2

This Part lists the Clinical Records reports. Their descriptions are organized as follows:

a. Definition - a brief description of the report or product, its purpose or function, frequency of production, distribution, and utilization.

   Some of the Clinical Records reports are requested from the Clerk Actions Screen in the Clinical Records function; others can be requested through the Clinical Records Reports function. When a report is requested from the Reports Screen, a Run-Time Information Screen is displayed, on which the user specifies the reporting period.

b. Format - the organization of the content of the output, and any header or trailer data it might include.

c. Content - a Data Chart describing each data element on the output.

d. Example - a sample of each output.

CLINICAL RECORDS RETURNED TO A&D

a. Definition. This report lists records that have been returned to R/ADT for correction, and gives patient data for each record. It is printed when the user requests it from the Clinical Records Report function. This report is distributed to Patient Administration, and is used to follow-up on necessary record corrections.

b. Format. The Records Returned report begins with the standard header data, and is arranged in table form.

c. Content.

(1) REG NO. Register number assigned to the inpatient episode.

(2) PATIENT NAME.

(3) FMP. Patient's family member prefix. Table 1012.

(4) SSN. Social Security Number of the patient's sponsor, or of the patient if the patient is the sponsor.

(5) DATE DISP. Date of this patient's disposition.

(6) RELEASED. Date when this patient record was released from CR control and returned to A&D.

(7) REASON RELEASED. The reason why this record was returned to A&D.

DATA CHART - CLINICAL RECORDS RETURNED TO A&D REPORT

TEST NAVY MTF RUN DATE: 31 AUG 1985

PERSONAL DATA - PRIVACY ACT 1974

CLINICAL RECORDS RETURNED TO A & D

*REG NO	PATIENT NAME	FMP	SSN	DATE: DISP	RELEASED *
*		REASON RELEASED			*
0006460	TEST,BABY	01	222-22-2222	29 AUG 1985	31 AUG 1985
		NAME ENTERED INCORRECTLY			
0006469	JONES,BOB	20	888-33-3121	30 AUG 1985	31 AUG 1985
		DATE OF DISPOSITION INCORRECT			

CLINICAL RECORDS RETURNED TO A&D

CODED EPISODE SUMMARY (CES)

a. Definition. The CES contains data summarizing an individual inpatient episode. It is a hard-copy version of the Coded Transcript Tape, and is requested from the Clinical Records function, Clerk Actions Screen. This output is distributed as determined by the MTF command; it is used as an historical file and in error control.

b. Format. The header for this output contains the following data: report title, page number, Privacy Act Statement, and run date. The report begins with the patient data described in the Data Chart below. The body of the report consists of card data that differs for each military department. The CES card data is described in a separate Data Chart for each military department, on the pages to follow.

c. Content.

(1) REG #. Patient's register number.

(2) NAME of patient.

(3) SEX.

(4) FMP/SSN.

(5) PNT CAT. Code for patient's patient category. Table 1002.

(6) DOB.

(7) RECORD CLERK. The initials associated with the user ID and password that were entered before the CES was requested.

(8) ADM DATE. Date and time of the admission.

(9) DISP DATE. Date and time of the disposition.

(10) SRC ADM. Code for the patient's source of admission. Table 2001.

(11) DISP TYPE. Type of the disposition. Table 2007.

(12) CAUSE. Code for cause of death or separation. Table 4001.

(13) CLN SVC. Code for the patient's clinical service assignment. Table 2005.

DATA CHART - CODED EPISODE SUMMARY, COMMON PATIENT DATA
(All Military Departments)

CARD A

(1) REGISTER. Patient's register number.

(2) MTF. Code for the MTF. Table 1005.

(3) FMP. Patient's family member prefix. Table 1012.

(4) SSN.

(5) BEN/CMD. For active duty patients, the major command code (Table 1017). For all others, the patient category code.

(6) GRADE. Patient's pay grade, if active duty. Translated from rank.

(7) AFSC. Military specialty code, if active duty Air Force. Table 1029.

(8) AV-SV. Aviation service code (flying status), if active duty Air Force. Table 1014.

(9) A-RAT. Aeronautical rating. Table 1009.

(10) L-SVC. Patient's length of service, in years, if active duty. Coded RR if unknown. Table 2014.

(11) AGE of patient. Table 4011.

(12) SEX.

(13) MSTAT. Patient's marital status.

(14) RACE. Table 1024. Table 2005.

(15) DUTYZ. Zip code of the patient's duty station, plus two zeroes.

(16) INIT-MTF. Code for the MTF to which the patient was originally admitted. If the patient was a transfer-in, the code for the first MTF to which he/she was admitted. Table 1005.

(17) IN-AD-DT. Date on which patient was initially admitted for this inpatient episode (Julian format).

(18) DISP-D. Date on which the patient was discharged (Julian format).

(19) DISP-TP. Code for type of disposition. Table 2007.

DATA CHART - CODED EPISODE SUMMARY (AIR FORCE)

(20) TO-DY-DT. Total number of days of the inpatient episode, from date of admission to date of disposition (the day of disposition is not counted unless the admission and disposition occurred on the same day).

(21) BD-DT. Total number of days, during this inpatient episode, that the patient had an absent status for which bed days are counted. (If the patient was a transfer-in, the inpatient episode consists of all days this patient spent in this MTF, plus bed days accrued in previous MTFs before transfer to this one.) If the patient was admitted and dispositioned on the same day, this number is 1.

(22) BD-FAC. Total number of days, during this inpatient episode at this MTF, that the patient had an absent status for which bed days are counted.

(23) CRD. The card identification letter (A).

CARD B

(1) REGISTER. Patient's register number.

(2) MTF. Code for this MTF. Table 1005.

(3) DIS-CLIN. Code for the clinical service on which the patient accumulated the greatest number of bed days during the inpatient episode. Table 2005.

(4) BED-DA. Total number of days, on this clinical service, that the patient had an absent status for which bed days are counted.

(5) CAUSE-INJ. Code for the class of trauma (Table 2016) and cause of injury (Table 2009), if any, as entered on Admission Screen.

(6) CAUSE-D/S. Code for the diagnosis that represents the underlying cause of death or separation. Table 4001.

(7) PRI-DIAG. The first diagnosis code entered for this patient on the CR Diagnosis Screen for this inpatient episode. Contains ICD code (Table 9001) and asterisk/secondary/dagger code (Table 4002).

(8) INF. Infectious data code associated with the first diagnosis. Table 4003.

(9) 2ND-DIAG. The second diagnosis code entered on the CR Diagnosis Screen. Contains ICD code (Table 9001) and asterisk/secondary/dagger code (Table 4002).

(10) INF. Infectious data code for the second diagnosis. Table 4002.

(11) 3RD-DIAG. The third diagnosis code entered on the CR Diagnosis Screen. Contains ICD code (Table 9001) and asterisk/secondary/dagger code (Table 4002).

(12) INF. Infectious data code for the third diagnosis. Table 4003.

(13) PRI-PROVDR. The numerical code for the primary provider of care associated with this inpatient episode.

(14) (POC ID). The alphabetic letter code for this provider. The code for the primary provider is always A.

(15) 2ND-PROVDR. The numerical code for the secondary provider.

(16) (POC ID). The alphabetical letter code for the secondary provider.

(17) 3RD-PROVDR. The numerical code for the third provider.

(18) (POC ID). The alphabetical letter code for the third provider.

(19) CONV-TAKEN. Number of days of convalescent leave taken.

(20) CONV-REC. Number of days of convalescent leave recommended.

(21) CRD. The card identification letter (B).

CARD C

(1) REGISTER. Patient's register number.

(2) MTF. Code of this MTF. Table 1005.

(3) OTH-CLIN. Code for clinical service on which the patient accumulated the second greatest number of bed days. Table 2005.

(4) BED-DA. Number of bed days accumulated while the patient was on the clinical service named in (3) above.

(5) OTH-CLN. Code for clinical service on which the patient accumulated the third greatest number of bed days. Table 2005.

(6) BED-DA. Number of bed days accumulated while the patient was on the clinical service named in (5) above.

(7) 1ST-OP. ICP code for the first procedure listed on the CR Procedure Screen.

(8) D. Code for where this procedure was performed. Table 4009.

(9) POCT. Single-letter code for the provider who performed this procedure. Can contain up to three codes for three different providers.

(10) 2ND-OP. ICP code for the second procedure listed on the CR Procedure Screen. Table 9002.

(11) D. Code for where this procedure was performed. Table 4009.

(12) POCT. Single-letter code for the provider who performed this procedure. Can contain up to three codes for three different providers.

(13) PRE-OP. Number of days after admission date (initial admission) and before first procedure was performed. Includes day of admission but not day of procedure. If procedure was performed on day of admission, this field contains a zero.

(14) POST-OP. Number of days after first procedure and before disposition date. The day of the procedure is counted; the day of disposition is not. If the procedure was performed on the day of disposition, this field contains a zero.

(15) VL-WHOL. Volume of whole blood transfused to this patient during this episode, in CCs.

(16) CC-PACK. Number of CCs of packed cells administered to this patient during this episode.

(17) - (20) FETUS1 - FETUS4. Code for presentation of fetus. Up to four codes can be entered. Table 4005.

(18) CRD. The card identification letter (C).

CARD D

(1) REGISTER. Patient's register number.

(2) MTF. Code of this MTF. Table 1005.

(3) 3RD-OP. ICP code for the third procedure listed on the CR Procedure Screen, if any. Table 9002.

(4) D. Code for where this procedure was performed. Table 4009.

(5) POCT. Single-letter code for the provider who performed this procedure. Can contain up to three codes for three different providers.

Fields (3) through (5) can be repeated 6 times, allowing data on as many as 7 additional procedures to be displayed on the D card. The last field on the card is the card identifier (D).

CARD E

(1) REGISTER. Patient's register number.

(2) MTF. Code of this MTF. Table 1005.

(3) 4TH-DIAG. The fourth diagnosis code entered on the CR Diagnosis Screen. Contains ICD code (Table 9001) and asterisk/secondary/dagger code (Table 4002).

(4) INF. Infectious data code associated with the fourth diagnosis. Table 4003.

Fields (3) and (4) are repeated 7 times, thus allowing data on as many as 8 additional diagnoses to be displayed on the E card. The last field on the card is the card identifier (E).

CARD F

(1) REGISTER. Patient's register number.

(2) MTF. Code of this MTF. Table 1005.

(3) 4TH-PROV. The numerical code for the 4th provider of care associated with this inpatient episode, as entered on the Clinical Records screens.

(4) DR. The alphabetic letter code for the 4th provider of care.

Fields (3) and (4) are repeated 8 times, thus allowing data on as many as 9 additional providers of care to be displayed on this card. The last field on this card is the card identifier (F).

Cards D, E, and F can be repeated if more data of the respective type exists. The single-letter card designation will be followed by an A, B, etc., for each continuation card. The last card for each patient will be indicated by the letter "L."

DATA CHART - CODED EPISODE SUMMARY (AIR FORCE)

*** CLINICAL RECORDS CODED EPISODE SUMMARY ***
PERSONAL DATA PRIVACY ACT OF 1974 20 JUN 1985

REG # 000318R NAME: LANE,JOE SEX: M EMP/SSN: 20 445-36-3736
PNT CAT: F11 DOB: 02 MAY 1945 RECORD CLERK: HKK
ADM DATE: 01 JUN 1985 1200 DISP DATE: 16 JUN 1985 1230
SRC ADM: DIR DISP TYPE: OTH CAUSE: 8111 CLN SVC: AOA

CARD A

REGISTER	MTF	EMP	SSN	BEN/CMD	GRADE	AFSC	AV-SV	A-RAT	I-SVC
1-8	9-14	15-16	17-25	26-28	29-30	31-33	34-35	36	37-38
0000318R	000654	20	445363736	ESC	05	000	25	0	18

AGE	SEX	MSTAT	RACE	DUTYZ	INIT-MTF	IN-AD-DT	DISP-D	DISP-TP	TD-DY-DT
39-40	41	42	43	44-50	51-56	57-61	62-66	67	68-70
40	M	M	C	9506400	000654	85152	85167	T	015

BD-DT	BD-FAC		CRD
71-73	74-76	77-78	79-80
012	012		A

CARD B

REGISTER	MTF	DIS-CLIN	<BED-DA	CAUSE-INJ	CAUSE-D/S	PRI-DIAG	<INF
1-8	9-14	15-17	18-20	21-24	25	26-31	32
0000318R	000654	AAA	009	8111	J	80000	0

2ND-DIAG	<INF	3RD-DIAG	<INF	PRI-PROVDR		2ND-PROVDR		3RD-PROVDR	
33-38	39	40-45	46	47-52	53	54-59	60	61-66	67
34820A	0			341093	A	987987	B	273641	C

CONV-TAKEN	CONV-REC		CRD
68-69	70-71	72-78	79-80
00	00		B

CARD C

REGISTER	MTF	OTH-CLIN	<BED-DA	OTH-CLIN	<BED-DA	(1ST-OP	D	POCT)
1-8	9-14	15-17	18-20	21-23	24-26	27-30	31	32-34
0000318R	000654	AAJ	003			3206	B	BC

(2ND-OP	D	POCT)	(3RD-OP	D	POCT)	PRE-OP	POST-OP	CL-WHOL	CC-PACK	FETUS1
35-38	39	40-42	43-46	47	48-50	51-53	54-56	57-61	62-66	67-68
3440		B	8920		D	001	014	00000	00020	

FETUS2	FETUS3	FETUS4		CRD
69-70	71-72	73-74	75-78	79-80
				C

*** CLINICAL RECORDS CODED EPISODE SUMMARY *** PAGE 2
PERSONAL DATA PRIVACY ACT OF 1974 20 JUN 1985

REG # 000318R NAME: LANE,JOE SEX: M EMP/SSN: 20 445-36-3736
PNT CAT: F11 DOB: 02 MAY 1945 RECORD CLERK: HKK
ADM DATE: 01 JUN 1985 1200 DISP DATE: 16 JUN 1985 1240
SRC ADM: DIR DISP TYPE: OTH CAUSE: 8111 CLN SVC: AOA

CARD F

REGISTER	MTF	4TH-PROV	DR	5TH-PROV	DR	6TH-PROV	DR	7TH-PROV	D
1-8	9-14	15-20	21	22-27	28	29-34	35	36 41	42
--------	------	------	-	------	-	------	-	------	-
0000318R	000654	123245	D						

8TH-PROV	DR	9TH-PROC	DR	10TH-PROV	DR	11-PROV	DR	12-PROV	DR		CRD
43-48	49	50-55	56	57-62	63	64-69	70	71-76	77	78	79-80
------	-	------	-	------	-	------	-	------	-	-	--
											F

CODED EPISODE SUMMARY (CES) (AIR FORCE)

CARD A

(1) MTF CODE. Code for this MTF. Table 1005.

(2) REG #. Patient's register number.

(3) GRADE. Patient's pay grade, if active duty. Translated from rank.

(4) SEX.

(5) AGE.

(6) RACE code. Table 1024.

(7) L-SVC. Length of service, in years.

(8) FMP. Family member prefix. Table 1012.

(9) SSN.

(10) BEN CAT. Patient's patient category code. First 2 characters followed by a zero (except for category X52). Table 1002.

(11) UIC/ZIP. Unit identification code or zip code of duty station.

(12) CASE TYPE. Army code for type case. Table 2004.

(13) ADM TYPE. Army code for source of admission (e.g., transfer). Table 2001.

(14) CLIN SVC. UCA code for patient's clinical service. Table 2005.

(15) DISP. Army code for type of disposition. Table 2007.

(16) DISP DATE. Date on which patient was dispositioned (Julian format).

(17) ADM DATE. Date on which patient was admitted (Julian format). If absent sick and subsequently became a bed occupant, the date of absent status change; for other absent sick cases, this field will be blank.

(18) INIT DATE. If patient was a transfer-in, the date on which the patient was first admitted to an MTF before transferring (Julian date). If the patient transferred more than once during this inpatient episode, the date on which he/she was admitted to the first MTF. If patient is absent sick, the date admitted to any non-military MTF.

DATA CHART - CODED EPISODE SUMMARY (ARMY)

Fields (19) through (23) contain the number of days that the patient accumulated for each of the absent statuses listed. This only includes days accumulated at this MTF.

(19) ABS SK. Number of days during which the patient was absent sick.

(20) OTH DAY. Number of days during which the patient had an absent status other than those reported in fields 19, 21, 22, or 23.

(21) CON LV. Number of days during which the patient's absent status was "convalescent leave" or "cooperative care."

(22) SUP CAR. Number of days during which the patient's absent status was "supplemental care."

(23) BED DAY. Number of days at this MTF that the patient had an absent status for which bed days are counted.

(24) TOT DAYS. Total number of days the patient spent at this MTF during this episode.

(25) TRF. Indicates whether patient was transferred to a VA hospital, or whether an autopsy was performed on the patient.

(26) CRD. Card identifier (A).

CARD B

(1) MTF CODE. Table 1005.

(2) REG #. Patient's register number.

(3) INIT MTF. If patient was a transfer-in, the code of the MTF to which the patient was admitted before transferring. If the patient transferred more than one time during this inpatient episode, the code of the first MTF to which he/she was admitted.

Fields (4) through (8) contain the total number of days that the patient accumulated for each of the absent statuses listed, including days accumulated at this MTF, and at any other MTFs the patient might have transferred from.

(4) TOT ABS. Total number of days the patient had an absent status of "absent sick."

DATA CHART - CODED EPISODE SUMMARY (ARMY)

(5) TOT OTH. Total number of days that the patient had an absent status other than those reported in fields 4, 6, 7, or 8.

(6) TOT CONV. Total number of days that the patient had an absent status of "convalescent leave" or "cooperative care."

(7) TOT SUP. Total number of days that the patient had an absent status of "supplemental care."

(8) TOT BED. Total number of days that the patient had an absent status for which bed days are counted.

(9) TOT SICK. Total number of days from initial admission to disposition.

(10) PREOP. Number of bed days before the first operation or procedure.

(11) INJ. Cause of injury code. Table 2009.

(12) CAUSE. Underlying cause of death or separation. Table 4001.

(13) COR. Indicates whether this record was submitted to higher command and then returned to the MTF and corrected.

(14) 1 DIAG. ICD code entered for the first diagnosis on the CR Diagnosis Screen. Table 9001.

(15) 2 DIAG. ICD code entered for the secondary diagnosis on the CR Diagnosis Screen. Table 9001.

(16) 3 DIAG. ICD code entered for the third diagnosis on the CR Diagnosis Screen. Table 9001.

(17) 1 OP. ICP code entered for the first procedure (i.e., operation) on the CR Procedure Screen. Table 9002.

(18) 2 OP. ICP code entered for the second procedure on the CR Procedure Screen. Table 9002.

(19) 3 OP. ICP code entered for the third procedure on the CR Procedure Screen. Table 9002.

(20) CRD. Card Identifier (B).

DATA CHART - CODED EPISODE SUMMARY (ARMY)

CARD C

(1) MTF CODE. Table 1005.

(2) REG #. Patient's register number.

(3) 4 DIAG. ICD code for the fourth diagnosis on the CR Diagnosis Screen. Table 9001.

(4) 5 DIAG. ICD code for the fifth diagnosis on the CR Diagnosis Screen. Table 9001.

(5) 6 DIAG. ICD code for the sixth diagnosis on the CR Diagnosis Screen. Table 9001.

(6) 7 DIAG. ICD code for seventh diagnosis. Table 9001.

(7) 8 DIAG. ICD code for eighth diagnosis. Table 9001.

(8) 4 OP. ICP code for the fourth procedure on the CR Procedure Screen. Table 9002.

(9) 5 OP. ICP code for the fifth procedure on the CR Procedure Screen. Table 9002.

(10) 6 OP. ICP code for the sixth procedure. Table 9002.

(11) 7 OP. ICP code for the seventh procedure. Table 9002.

(12) 8 OP. ICP code for the eighth procedure. Table 9002.

(13) RESIDUAL DISABILITY. Code indicating the level of the patient's disability, if any.

(14) CRD. Card identifier (C).

DATA CHART - CODED EPISODE SUMMARY (ARMY)

*** CLINICAL RECORDS CODED EPISODE SUMMARY ***
PERSONAL DATA PRIVACY ACT OF 1974 20 JUN 1985

REG # 0000028 NAME: THOMAS,IRENE SEX: F EMP/SSN: 20 987-23-8781
PNT CAT: A12 DOB: 23 MAY 1952 RECORD CLERK: HKK
ADM DATE: 01 JUN 1985 1700 DISP DATE: 10 JUN 1985 1200
SRC ADM: 1 DISP TYPE: A CAUSE: CLN SVC: AD

CARD A

MTF CODE	REG #	GRADE	SEX	AGE	RACE	I-SVC	EMP	SSN	BEN CAT
1-4	5-11	12-13	14	15-16	17	18-19	20-21	22-30	31-33
2131	0000028	E8	F	33	1	11	20	987238781	A10

UIC/ZIP	CASE TYPE	ADM TYPE	CLIN SVC	DISP	DISP DATE	ADM DATE	INIT DATE
34-38	39	40	41-42	43	44-48	49-53	54-58
	9	1	AD	A	85161	85152	

ABS SK	OTH DAY	CON LV	SUP CAR	BED DAY	TOT DAYS	TRF		CRD
59-61	62-64	65-67	68-70	71-73	74-76	77	78-79	80
000	000	003	000	006	009			A

CARD B

MTF CODE	REG #	INIT MTF	TOT ABS	TOT OTH	TOT CONV	TOT SUP	TOT BED
1-4	5-11	12-15	16-18	19-21	22-24	25-27	28-30
2131	0000028		000	000	003	000	006

TOT SICK	PREOP	INJ	CAUSE	COR	1 DIAG	2 DIAG	3 DIAG	1 OP	2 OP
31-33	34-35	36-38	39	40	41-47	48-54	55-61	62-67	68-73
009	00				6860				

3 OP	CRD
74-79	80
	B

CODED EPISODE SUMMARY (CES) (ARMY)

CARD A

(1) CARD. Card identifier (A).

(2) UIC. Unit identification code for this MTF.

(3) REG#. Patient's register number.

(4) ADM DATE. Admission date.

(5) PNT NAME.

(6) PNT-UIC-LOC. If patient is active duty, the unit identification code or station code.

(7) FMP/SSN of patient. See Table 1012 for family member prefix.

(8) SEX.

(9) RACE code. Table 1024.

(10) ADM TYPE. Code for source of admission. Table 2001.

(11) WARD. ID number of patient's ward.

(12) ZIP. If patient is active duty, the duty station zip code.

(13) LOC. AQCESS only operates at fixed facilities. This field is only used for field activities.

CARD B

(1) CARD. Card identifier (B).

(2) UIC. Unit identification code for this MTF.

(3) REG#. Patient's register number.

(4) DOB.

(5) LOS. Length of service, in the format YYMM (0000 to 5511).

(6) PAY GR. Patient's pay grade, if active duty. Translated from rank.

(7) MOS. Code for patient's military specialty. Table 1029.

DATA CHART - CODED EPISODE SUMMARY (NAVY)

(8) MTO. Code for military theater of operations. Table 2008. Coded 99 if not applicable.

(9) TRANS/FROM. Code for MTF from which the patient transferred, if any. Table 1005.

(10) ORIG ADM DATE. Patient's admission date. If patient is a transfer-in, the date on which the patient was admitted to the first hospital from which he/she transferred.

(11) PNT CAT. Code for patient's patient category. Table 1002.

(12) CLIN SVC. Code for patient's clinical service. Table 2005.

(13) ADM DIAG. ICD code for the diagnosis made at this patient's admission. Table 9001.

(14) ADM CAUSE INJ. Code for the cause of injury, if any, entered at admission. Table 2009.

CARD D

The CES may include more than one D card, depending on the number of diagnoses entered for the inpatient episode. As many as 8 diagnoses, and thus 8 D cards, can be included.

(1) CARD. Card identifier (D).

(2) UIC. Unit identification code for this MTF.

(3) REG#. Patient's register number.

(4) ABS DAYS. The number of non-bed days accrued by the patient during this inpatient episode.

(5) TFR TO. Code for the MTF to which the patient transferred to, if the patient was a transfer-out. Table 1005.

(6) #DIAG. The number of diagnoses recorded for this episode on the CR Diagnosis Screen. Maximum number that can appear in this field is 8.

(7) DIAG#. The number of the diagnosis as it appears on the CR Diagnosis Screen.

(8) OCC. Indicates whether the condition referred to in field (7) is related to occupation (Y/N).

(9) EPTE. Indicates whether the condition referred to in field (7) existed prior to entry into the service (Y/N).

(10) ICD. ICD code of the diagnosis referred to in (7). Table 9001.

(11) CAUSE. If the condition just diagnosed was due to injury, the codes for the type of trauma (Table 2016) and cause of the injury (Table 2009).

(12) SURG?. Indicates whether surgery was performed (Y/N). If at least one procedure was entered on the CR Procedure Screen for this inpatient episode, this field will contain Y; if no procedures were entered, this field will contain N.

(13) #SURG. The number of the procedure entered on the CR Procedure Screen.

(14) ICP. The ICP code for the procedure referred to in field (13). Table 9002.

(15) DATE INIT. The initial date the surgery was performed.

(15) TR DATE. Transaction date. The date on which the transaction was effective. In this field, it is always the same as the date of disposition.

(16) TR TYPE. The type of transaction for which this D card has been generated.

(17) C LEAV. The number of convalescent leave days recommended.

CARD H (Correction Card)

H cards are generated to correct errors previously transmitted on A, B, D, or M cards. More than one H card can be submitted.

(1) CARD. Card identifier (H).

(2) TR TYPE. The transaction type. On correction cards, the transaction type is always C.

(2) FACILITY CODE. Unit ID code for this MTF.

(3) REGISTER NUMBER.

(4) FIELD ID. Identification of the field to be corrected by this card.

(5) REPLACEMENT DATA. The contents of the correction for the Navy's master records.

(6) DISPOSITION DATE. In the format YYMM.

CARD C (Workload Reporting Card)

C cards are generated by specific events that can occur during an inpatient episode (e.g., patient transfers out, patient's admission is cancelled, etc.). More than one C card can be submitted for one inpatient episode.

(1) CARD. Card identifier (C).

(2) UIC. Unit ID code for this MTF.

(3) REG#. Register number of patient.

(4) BEGIN DATE THIS TRANS. The beginning date of the transaction. If this is the first transaction since admission, the begin date will be the date of admission. Otherwise, the begin date is the date of the last transaction. In the format DDMMYY.

(5) DAYS. The number of bed days accrued between the begin date and the transaction date.

(6) PAT CAT. The patient category effective when the C card was created. Table 1002.

(7) CLIN SVC. The clinical service in effect during this transaction. Table 2005.

(8) ADM TYP. The type of admission. Table 2001.

(9) MTO. Military theater of operations. Table 2008.

(10) WARD. The ID of the ward the patient was on during this transaction.

(11) DATE THIS TRANS. The transaction date. Usually, the effective date of the event or change, but this depends on the type of transaction. For example, if the C card was generated because the patient remained in the MTF over the end of the month, the transaction date is the first day of the new month.

(12) TRANS TYPE. The transaction type for which this card was generated.

(13) COR FLAG. If this card represents a correction to a previous C card, this field will contain a C.

CARD M (Medical Holding Company Disposition Card)

M cards are generated when a patient is released from a Medical Holding Company.

(1) CARD. The card identifier (M).

(2) UIC. Unit ID code for this MTF.

(3) REG#. Patient's register number.

(4) DATE OF DISCHARGE. Date of release from the Medical Holding Company. In format DDMMYY.

(5) TRANS TYPE. The type of transaction for which this card was generated.

CARD Z (Transmittal Card)

This card is not included in the Coded Episode Summary, but accompanies the Coded Transcript Tape. It lists the number of each type of card being submitted for the inpatient episode.

DATA CHART - CODED EPISODE SUMMARY (NAVY)

*** CLINICAL RECORDS CODED EPISODE SUMMARY ***
PERSONAL DATA PRIVACY ACT OF 1974 05 JUN 1985

REG # 0000176 NAME: HOBBY,MAC SEX: M EMP/SSN: 20 214 56-7812
PNT CAT: N11 DOB: 02 AUG 1948 RECORD CLERK: HNK
ADM DATE: 02 JUN 1985 1330 DISP DATE: 14 JUN 1985 1300
SRC ADM: DIR DISP TYPE: HOME CAUSE: CLN SVC: ABF

CARD A

CARD	UIC	REG#	ADM DATE	PNT NAME	PNT-UIC-LOC	EMP/SSN	SEX
1	2-6	7-13	14-19	20-33	34-40	41-51	52
A	00168	0000176	020685	HOBBY,MAC	20312	20214567812	M

RACE	ADM TYPE	WARD	ZIP		LOC	
53	54-55	56-59	60-64	65-68	69-70	71-80
C	00	3S	24218			

CARD B

CARD	UIC	REG#	DOB	LOS	PAY GR	MOS	MTO	TRANS/FROM
1	2-6	7-13	14-19	20-23	24-25	26 27	28-29	30-33
B	00168	0000176	090848	1502	04	16	6	

ORIG ADM DATE	PNT CAT	CLIN SVC	ADM DIAG	ADM CAUSE INJ
34-39	40-42	43-46	47-52	53-56
020685	N11	ABF	80230	111

57-80

CARD D

CARD	UIC	REG#		ABS DAYS	TFR TO	#DIAG	DIAG#
1	2-6	7-13	14-36	37-39	40-43	44	45
D	00168	0000176		000		1	1

OCC	EPTE	ICD	CAUSE	SURG?	#SURG	ICP	DATE INIT	TR DATE	TR TYPE
46	47	48-53	54-57	58	59	60-63	64-69	70-75	76-77
		80230	8110	Y	2	1302	030685	110685	10

C LEAV

78-79	80
00	

CODED EPISODE SUMMARY (CES) (NAVY)

*** CLINICAL RECORDS CODED EPISODE SUMMARY *** PAGE 2
PERSONAL DATA PRIVACY ACT OF 1974 05 JUN 1985

REG # 0000176 NAME: HOEBY,MAC SEX: M ENP/SSN: 20 214 56-7812
PNT CAT: N11 DOB: 09 AUG 1918 RECORD CLERK: HNK
ADM DATE: 02 JUN 1985 1330 DISP DATE: 14 JUN 1985 1300
SRC ADM: DIR DISP TYPE: HOME CAUSE: CLIN SVC: ABF

CARD D

CARD	UIC	REG#		ABS DAYS	TFR TO	#DIAG	DIAG#
	2-6	7-13	14-36	37-39	40-43	44	45
D	00168	0000176		000		1	

SEC	EPTE	ICD	CAUSE	SURG?	#SURG	TOP	DATE INIT	TR DATE	TR TYPE
46	47	48-53	54-57	58	59	60-63	64-69	70-75	76-77
				Y	2	5034	040685	140685	10

C LEAV
78-79 80
00

CARD C

CARD	UIC	REG#	BEGIN	DAYS	PAT CAT	CLIN SVC	ADM TYPE	MTD	WARD
1	2-6	7-13	14-19	20-21	22-24	25-28	29-30	31-32	33-36
C	00168	0000176	020685	12	N11	ABF	00	99	35

37-69	TR DATE	TR TYPE		C FLAG
	70-75	76-77	78-79	80
	140685	10		

CODED EPISODE SUMMARY (CES) (NAVY)

CODED TRANSCRIPT TAPE (CTT)

The Coded Transcript Tape is a machine-readable report on records that have been processed in the Clinical Records subsystem and approved for inclusion on this tape by the Clinical Records supervisor. This output includes final records on patients. The CTT is distributed to higher headquarters and is used in biomedical statistical and workload reporting.

The Coded Episode Summary is the hard-copy version of the CTT; for details on format and content, see the description of the Coded Episode Summary in this appendix.

For the Army, the CTT consists of two tapes: the ABC card tape and the X&Y card tape. The ABC card tape contains the data that appears on the Army Coded Episode Summary. The X card tape contains one record for each disposition in the month, and the Y card contains totals for that month.

END-OF-MONTH SUMMARY

a. Definition. The End-of-Month Summary is produced and used by the Navy only. It gives summary statistics for inpatient activity--specifically, on all admissions and dispositions for the month, giving figures for those that have been completely processed in CR and those that are incomplete. The End-of- Month Summary is requested by Navy users from the Clinical Records Report function. Distribution of this report is determined by the MTF command.

b. Format. The header for this report contains the MTF name, the run date and time, the report title, and the time period for which the report is effective. The body of the report is arranged in the form of a grid, containing the data described below.

c. Content. This report gives totals for the previous month and the current month.

For the previous month, this report gives the number of patients remaining at the end of the month who are:

- Inpatients, whose records are completely processed in Clinical Records
- Inpatients, whose records are incompletely processed in Clinical Records
- Newborns (with mother), whose records are completely processed in Clinical Records
- Newborns (with mother), whose records are incompletely processed in Clinical Records.

Patients for the current month are grouped according to admissions and dispositions. Admissions are further subdivided by the following sources of admission:

- Direct (direct admission)
- Transfer (transfer-in)
- Live birth
- Retained
- Total.

Dispositions are subdivided by the following types of disposition:

- Transfer (transfer-out)
- Duty/home
- MHC (Medical Holding Company)
- Conv leave (convalescent leave)
- Died
- Retained.

For each of these categories the following figures are given:

- Inpatients, whose records are completely processed in Clinical Records

- Inpatients, whose records are incompletely processed in Clinical Records

- Newborns (with mother), whose records are completely processed in Clinical Records

- Newborns (with mother), whose records are incompletely processed in Clinical Records.

A total for each of these four figures is also given, along with the total number of patients in each category remaining at the end of the month.

Note: Fields marked with X on the example will never contain data. "A" fields will always be equal, and "B" fields will always be equal.

TEST NAVY MTF

RUN DATE: 31 AUG 1985
TIME: 1723

*** CLINICAL RECORDS END OF MONTH SUMMARY ***

EFFECTIVE 01 AUG 1985 - 31 AUG 1985

PATIENT CATEGORY	INPATIENTS		NEWBORNS WITH MOTHER	
ALL CATEGORIES	COMPLETE	INCOMPLETE	COMPLETE	INCOMPLETE
PREVIOUS MONTH				
REMAINING END OF MONTH	4			
CURRENT MONTH				
ADMISSIONS				
DIRECT	1	19	X	X
TRANSFER	1	1	X	X
LIVE BIRTH	X	X		5
RETAINED	(A)	1(B)	X	X
TOTAL	2	21		5
DISPOSITIONS				
TRANSFER		1		
DUTY/HOME	2	7		3
MHC			X	X
CONV LEAVE			X	X
DIED		1		
RETAINED	X	X	(A)	1(B)
TOTAL	2	9	0	4
REMAINING END OF MONTH	16		1	

END-OF-MONTH SUMMARY

ERROR LIST

a. Definition. This output lists any errors in the record that were discovered by Clinical Records edits. It is automatically printed after the Coded Episode Summary or the draft version of the ITRCS or RIPT. Distribution of this output is determined by the MTF command.

b. Format. The header for this output consists of the report title, the page number, the Privacy Act Statement, and the run date. The Error List begins with data on the patient whose record contains errors, as described in the Data Chart, and then lists the errors found in the record.

c. Content. The patient data displayed is described in the Data Chart below. Following the patient data, the errors found in the record are listed. The number of the error message is given, followed by the message itself. (The error message may be followed by another number, which is for programming use only.)

(1) REG #. Register number of patient.

(2) NAME of patient.

(3) SEX.

(4) FMP/SSN. Family member prefix and sponsor's Social Security Number. See Table 1012 for FMPs.

(5) PNT CAT. Code for the patient's patient category. Table 1002.

(6) DOB. Patient's date of birth.

(7) RECORD CLERK. Clerk's initials associated with the user ID and password that were used when the Error List was produced.

(8) ADM DATE. Date and time of admission.

(9) DISP DATE. Date and time of disposition.

(10) SRC ADM. Source or type of admission. Table 2001.

(11) DISP TYPE. Type of disposition. Table 2007.

(12) CAUSE. Single-digit class of trauma code (Table 2016) followed by cause of injury code (Table 2009).

(13) CLN SVC. Code for patient's clinical service. Table 2005.

DATA CHART FOR ERROR LIST, PATIENT DATA

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                    *** CLINICAL RECORDS ERROR LIST ***                    PAGE 3
                     PERSONAL DATA PRIVACY ACT OF 1974        19 JUN 1985

REG # 0000176  NAME: HOBBY,MAC                    SEX: M FMP/SSN: 20 214-56 7812
PNT CAT: N11                    DOB: 09 AUG 1948    RECORD CLERK: HKK
ADM DATE: 02 JUN 1985 1330                          DISP DATE: 13 JUN 1985 0900
SRC ADM: DIR                    DISP TYPE: HOME     CAUSE:       CLN SVC: ABC
-------------------------------------------------------------------------------
DIAGNOSIS # 80230  8110
 47  EXISTED PRIOR TO ENTRY CANNOT BE BLANK FOR ACTIVE DUTY USUS IF ICD CODE IS ENTERED   124-1

 46  OCCUPATIONAL-RELATED MUST BE 'Y' OR 'N'   182-1


CLINICAL RECORDS EDIT FAILED FOR THIS PATIENT
```

INCOMPLETE INPATIENT MEDICAL RECORDS REPORT

a. Definition. This report lists incomplete patient records under the name of the provider who is responsible for the missing record item(s). It reflects data entered on the CR Record Tracking Screen, and is organized in alphabetical order by patient name. The user can specify the responsible provider, or leave the provider field blank, and the report will sort and print data for all providers. This report is printed on request.

b. Format. The header for this report contains the MTF name, the run date, the Privacy Act Statement, the report title, and the name of the provider. The body of the report is in table form, and contains the data described below.

c. Content.

(1) PATIENT NAME. Name of the patient whose chart is incomplete. An asterisk before the patient's name means that the record is delinquent.

(2) REG NO. of the patient.

(3) DISP DATE. Date of the patient's disposition.

(4) AVAIL DATE. Date on which the patient's record was accessed through the Clinical Records function.

Fields (5) through (10) represent parts of the patient chart. The letter "S" in one of these fields means that the physician's signature is missing from this item; the letter "D" means that the dictation for this item is missing.

(5) H/P. History/physical.

(6) NS. The narrative summary.

(7) OP. Report on procedures performed.

(8) DO. Discharge order.

(9) DN. Discharge note.

(10) OS. An "S" in this field means that the provider is listed under "Other Missing Signatures" for this record.

DATA CHART - INCOMPLETE INPATIENT MEDICAL RECORDS REPORT

TEST NAVY MTF RUN DATE 31 AUG 1985

PERSONAL DATA - PRIVACY ACT 1974

INCOMPLETE INPATIENT MEDICAL RECORDS

PROVIDER: DILLON, JOHN

PATIENT NAME / REG NO	DISP DATE	AVAIL DATE	H/P	NS	OP	DO	DN	OS
ANDREWS,FRANK 0006491	11 AUG 1985	31 AUG 1985	SD					
* M,MOM 0006464	21 AUG 1985	29 AUG 1985		S		D		
WINSTON,MARIE 0006492	29 JUL 1985	31 AUG 1985	SD					

ASTERISK BEFORE PATIENT NAME DENOTES A DELINQUENT RECORD.

INCOMPLETE INPATIENT MEDICAL RECORDS REPORT

RECORD OF INPATIENT TREATMENT (RIPT) or INPATIENT TREATMENT RECORD COVER SHEET (ITRCS)

a. Definition. This report is called the Record of Inpatient Treatment by the Air Force and Navy, and the Inpatient Treatment Record Cover Sheet by the Army. It contains data on an individual inpatient episode that has been accessed in Clinical Records. It is requested by the user from the Clinical Records function, Clerk Actions Screen. This report is used as the patient chart, and provides identifying information on the patient and the hospital episode.

b. Format. The header for these reports varies according to military department. The Army ITRCS header contains only the report title and page number. The Air Force and Navy RIPT header displays the following:

- RUN DATE
- REPORT TITLE
- PAGE NUMBER
- RUN TIME
- PRIVACY ACT STATEMENT
- MTF CODE

The header of the RIPT also indicates whether this is a draft report.

The Army ITRCS is produced on a preprinted form that is inserted into the printer. It is in the form of a grid, with one or more data items to a block of the grid. The Air Force and Navy RIPTs contain data items grouped into sections separated by dashed lines.

The Air Force and Navy RIPTs include a trailer, giving the patient's register number, name, FMP and SSN, and indicating whether this page marks the end of the report or whether the report continues. The Air Force trailer also displays the statement "REPLACES AF FORM 565."

c. Content. The Army ITRCS contains most of the same fields as the Army Admission Cover Sheet, as described in the Data Chart on the next page. Because the RIPTs for the Air Force and Navy are very similar, they are described together in the second Data Chart.

(1) REGISTER NUMBER of patient.

(2) NAME of patient (last name, first, middle initial).

(3) GRADE. Rank of the patient, if active duty. Table 1006.

ADMISSION REMARKS.

(4) SEX of patient.

(5) AGE of patient.

(6) RACE. Table 1024.

(7) RELIGION. Table 1000.

(8) LENGTH OF SVC. Length of military service, if patient is a sponsor.

(9) ETS. Date when patient's term of service will expire. Can show INDEF if that date is indefinite.

(10) PREVIOUS ADMISSION. "YES" in this field indicates that this patient has previously been admitted to this MTF.

(11) FMP. Patient's family member prefix. Indicates relationship of patient to sponsor. Table 1012.

(12) SSN.

(13) ORGANIZATION authorizing patient's admission.

(14) WARD.

(15) FLYING STATUS. Flying status or aviation status code of patient. Table 1014.

(16) RATING/DSG. Patient's aeronautical rating. Table 1009.

(17) DEPT/BEN. For active duty patients, this field contains the military department. For others, it gives the patient category (Table 1002).

(18) BRANCH/CORPS. For Army officers, Army branch of service. For Army enlisted, this field will be blank. Table 1023.

(19) UIC/ZIP. Unit Identification Code or zip code of patient's sponsor, or of patient if patient is a sponsor.

DATA CHART - INPATIENT TREATMENT RECORD COVER SHEET (ITRCS) (ARMY)

(20) TYPE CASE. Table 2004.

(21) SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION. Source of the patient's admission; code and description; Table 2001. Also, the source of authorization for the patient's admission.

(22) HOUR OF ADMISSION.

(23) CLINIC SERVICE. Short description. Table 2005.

(24) NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE. Name of emergency addressee or next of kin, and his/her relationship to the patient. See Table 2012 for relationship.

(25) TYPE DISPOSITION. Code indicating patient's disposition status at the end of hospitalization. Table 2007.

(26) DATE OF DISPOSITION.

ADMITTING OFFICER.

(27) ADDRESS OF EMERGENCY ADDRESSEE (INCLUDE ZIP CODE). Also: TELEPHONE NO. of emergency addressee.

(28) DATE OF THIS ADMISSION.

(29) NAME AND LOCATION OF MEDICAL TREATMENT FACILITY.

(30) DATE OF INITIAL ADMISSION. If this patient is a transfer-in, the date when the patient was admitted to the MTF he or she transferred from.

(31) SELECTED ADMINISTRATIVE DATA. Free text.

(32) UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED. Calculated from number of CCs entered on Miscellaneous Screen.

(33) CAUSE OF INJURY. Description. Table 2009.

(34) DIAGNOSIS/OPERATIONS AND SPECIAL PROCEDURES. Patient's diagnosis and any operations or special procedures performed.

DATA CHART - INPATIENT TREATMENT RECORD COVER SHEET (ITRCS) (ARMY)

(35) TOTAL DAYS THIS FACILITY. Number of days the patient spent at this MTF under the following absent statuses:

a. ABSENT SICK.
b. OTHER DAYS.
c. CONV LV/COOP CARE. Convalescent leave or cooperative care.
d. SUPPLEMENTAL CARE.
e. BED DAYS. Number of days the patient spent at this MTF on absent statuses for which bed days are counted.
f. TOTAL SICK DAYS. Total number of days in fields a through e.

(36) TOTAL DAYS ALL FACILITIES. If this inpatient episode includes days at other MTFs from which the patient transferred, the days figures for the current and previous MTFs are presented here, broken down by the same absent statuses as in item (35) above. If this patient was not a transfer-in, line 35 is repeated.

SIGNATURE OF ATTENDING MEDICAL OFFICER. Name of the attending physician. Table 1004.

SIGNATURE OF PAD OR MEDICAL RECORD OFFICER. Name of the Medical Records Supervisor. Table 4000.

DATA CHART - INPATIENT TREATMENT RECORD COVER SHEET (ITRCS) (ARMY)

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40 - 400; the proponent agency is the Office of The Surgeon General

1. REGISTER NUMBER: 0000026		2. NAME (Last, First, MI): THOMAS, IRENE				3. GRADE: MSG	ADMISSION REMARKS
4. SEX: F	5. AGE: 33	6. RACE: 1	7. RELIGION:	8. LENGTH OF SVC: 11	9. ETS: INDEF	10. PREVIOUS ADMISSION: NO	
11. FMP: 20		12. SSN: 987238781		13. ORGANIZATION:		14. WARD: 3S	
15. FLYING STATUS: 76	16. RATING/DSG: 0	17. DEPT BEN: ARMY	18. BRANCH/CORPS.:	19. UIC/ZIP: 22312		20. TYPE CASE: INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIR DIRECT ADMISSION AR 40-3 PARA 4-1				22. HOUR OF ADMISSION: 1700	23. CLINIC SERVICE: DERM		
24. NAME, RELATIONSHIP OF EMERGENCY ADDRESSEE: THOMAS, FRANK/HUSBAND				25. TYPE DISPOSITION: DUTY	26. DATE OF DISPOSITION: 24 JUN 1985		ADMITTING OFFICER: COSBY, JOHN
27. ADDRESS OF EMERGENCY ADDRESSEE (INCLUDE ZIP CODE): 13 MARSHALL S ALEXANDR VA 22312				TELEPHONE NO.:	28. DATE OF THIS ADMISSION: 01 JUN 1985		32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: 0000					30. DATE OF INITIAL ADMISSION:		

31. SELECTED ADMINISTRATIVE DATA

Check If Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSIS/OPERATIONS AND SPECIAL PROCEDURES

DG 1. 6860 - -

PYODERMA

☐ Check If Continued on Reverse

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	3	0	20	23

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	3	0	20	23

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORD OFFICER

INPATIENT TREATMENT RECORD COVER SHEET (ITRCS) (ARMY)

(1) REGISTER. Register number of patient whose data is contained in this RIPT.

(2) NAME of patient.

(3) FMP/SSN. Patient's family member prefix (Table 1012) and SSN.

(4) ADMISSION: DATE/TIME.

(5) SOURCE. Source of admission. Table 2001.

(6) WARD. ID of patient's ward.

(7) TYPE CASE. Table 2004.

(8) PNT CATEGORY. Description of the patient category. Table 1002.

(9) BRANCH OF SERVICE. Military department of patient, if a sponsor, or of the patient's sponsor. Table 1023.

(10) GRADE. Patient's pay grade. Translated from rank. Air Force only.

(11) LENGTH OF SVC. Air Force only.

(12) MIL SPEC. Patient's military occupation or specialty. Table 1029. Air Force only.

(13) FLY STATUS. Patient's flying status. Table 1014. Air Force only.

(14) CIV OCC. Civilian occupation. Displayed for dependents only. Navy only.

(15) MARITAL STATUS.

(16) SEX.

(17) RACE. Table 1024.

(18) DOB.

(19) RELIGION. Description of patient's religious preference. Table 1000.

DATA CHART - RECORD OF INPATIENT TREATMENT (RIPT) (AIR FORCE AND NAVY)

(20) RECORDS RECEIVED. Indicates whether the following have been received at this MTF: HR (health record), DR (dental record), SR (service record), PR (pay record), ORD (orders), PE (personal effects). Navy only.

(21) AERO RATING. Patient's aeronautical rating. Description. Air Force only. Table 1009.

(22) AVIATION SERVICE CODE. Also known as flying status. Air Force active duty only. Table 1014.

(23) DISPOSITION: DATE/TIME.

(24) TYPE of disposition. Code, from Table 2007.

(25) UNDERLYING CAUSE. Code for cause of death or separation. Table 4001.

(26) FACILITY TFR TO. Code for the MTF transferred to, if any. Table 1005.

(27) SELECTED ADMINISTRATIVE DATA. Free text, from Administrative Data Screen in Clinical Records.

(28) CAUSE OF INJURY. Code and description for the cause of the injury that led to this hospitalization, if any. Table 2009.

(29) SPONSOR NAME. Air Force only.

(30) DUTY ADDRESS of sponsor. Air Force only.

(31) NXT OF KIN RELATIONSHIP. Relationship of next of kin to patient. Table 2012.

(32) NAME of next of kin.

(33) ADDRESS of next of kin.

(34) EMERGENCY RELATIONSHIP. Relationship of emergency contact to patient. Table 2012.

(35) NAME of emergency contact.

(36) ADDRESS of emergency contact.

(37) PATIENT ADDRESS. Street, city, state, zip code.

DATA CHART - RECORD OF INPATIENT TREATMENT (RIPT) (AIR FORCE AND NAVY)

(38) HOME PHONE of patient.

(39) WORK PHONE of patient.

(40) PRIMARY MTF. Code for the primary MTF responsible for the care of this patient. Table 1005.

DIAGNOSES

(41) ICD. ICD code of the diagnosis. Table 9001.

(42) (TEXT). The textual description of the diagnosis indicated by the ICD code. Table 9001. A second line displays the description of the cause of injury; the cause of injury line is a Navy-only field.

(43) OCCUPATION RELATED. Indicates whether this condition is related to the patient's occupation (Y/N). Navy only.

(44) EPTE. Indicates whether this condition existed prior to the patient's entry into the service. Y/N. Navy active duty only.

(45) CAUSE. Code of the cause of injury associated with this diagnosis, if any. Table 2009. Navy only.

(46) INF. Infection code (7th digit of ICD field on the CR Diagnosis Screen). Table 4003. Air Force only.

Data fields in the Diagnosis section are repeated for each diagnosis that entered for the patient.

PROCEDURES

(47) PROCEDURE. ICP code of the procedure performed. Table 9002.

(48) DATES. Date or date on which this procedure was performed. If performed more than once, the second date is the last date the procedure was performed.

(49) (TEXT). Description of the procedure. Table 9002.

(50) PROVIDER TEAM. Names of the doctors who performed this procedure on this patient.

Data fields in the Procedure section are repeated for each procedure entered for the patient.

DATA CHART - RECORD OF INPATIENT TREATMENT (RIPT) (AIR FORCE AND NAVY)

NON-PROCEDURAL PROVIDERS

(51) PRIMARY PROVIDER. Name of the person entered as the attending or primary provider on the CR Miscellaneous Screen.

EPISODE DAY SUMMARY

(52) THIS MTF. Code. Table 1005.

(53) ADMIT DATE. Date and time when the patient was admitted to this MTF.

(54) DISP DATE. Date and time when the patient was discharged from this MTF.

(55) TOT DAYS. Total number of days the patient spent at this MTF.

(56) BED DAYS. Number of days the patient spent on an absent status for which bed days are counted (at this MTF).

(57) NON-BED DAYS. Number of days the patient spent on an absent status for which bed days are not counted (at this MTF).

(58) (WARD). Name of the ward the patient was assigned to.

(59) TOT DAYS. Number of days the patient spent on that ward.

(60) (ABSENT STATUS). Name of the patient's primary absent status.

(61) BED DAYS. Number of bed days the patient spent on this absent status.

(62) NON-BED DAYS. Number of non-bed days the patient spent on this absent status.

(63) DATE ASSIGNED. Date when the patient was assigned to this absent status.

(64) TOTAL DAYS THIS MTF. Three fields on this line display the following: (a) the total number of days the patient spent at this MTF; (b) the number of days the patient spent, at this MTF, on an absent status for which bed days are counted; and (c) the number of days the patient spent, at this MTF, on an absent status for which bed days are not counted.

(65) TOTAL PRIOR MTFS, NON-MILITARY FACILITIES AND TRANSIT. Three fields on this line display data on days the patient spent at any non-military facilities or at any prior MTFs before transferring to this MTF, or in

EPISODE DAY SUMMARY (continued)

(65) TOTAL PRIOR MTFS, NON-MILITARY FACILITIES AND TRANSIT (cont'd.). transit between facilities. These fields display the following: (a) the total number of days the patient spent at all three; (b) the number of days the patient spent at all three while on absent statuses for which bed days are counted; and (c) the number of days the patient spent at all three while on absent statuses for which bed days are not counted.

(66) TOTAL DAYS TO DATE. Three fields on this line display the following: (a) the total number of days the patient spent at this MTF and any prior MTFs; (b) the number of days the patient spent on bed-day absent statuses at this MTF and any prior MTFs; and (c) the number of days the patient spent on non-bed-day absent statuses at this MTF and any prior MTFs.

(67) CONVALESCENT LEAVE TAKEN. Number of days the patient was on convalescent leave.

(68) RECOMMENDED. Number of convalescent leave days recommended.

OTHER RESOURCES

(69) CC-WHOLE BLOOD. Number of CCs whole blood transfused.

(70) CC-PACKED CELLS. Number of CCs packed cells administered.

(71) PRE-OP DAYS. Number of days between date of admission and date of first procedure (day of admission is counted, but not day of procedure).

(72) POST-OP DAYS. Number of days between date of last procedure and date of disposition (day of last procedure is counted, but not day of disposition).

(73) COOPERATIVE CARE DAYS, THIS MTF. Number of days that the patient spent on cooperative care while being tracked by this MTF.

(74) COOPERATIVE CARE DAYS, PRIOR MTFS. Number of days that the patient spent on cooperative care while being tracked by any previous MTFs (before transfer to this MTF).

(75) SUPP CARE DAYS, THIS MTF. Number of days that the patient spent on supplemental care while being tracked by this MTF.

(76) SUPP CARE DAYS, PRIOR MTFS. Number of days that the patient spent on supplemental care while being tracked by any previous MTFs (before transfer to this MTF).

RUN DATE: 24 JUN 1985 **** RECORD OF INPATIENT TREATMENT ****
TIME: 1542 PERSONAL DATA - PRIVACY ACT OF 1974
MTF: 0654

*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****

REGISTER: 0000321 NAME: DERRICK,JAKE FMP/SSN: 20 313-90-8283

ADMISSION: DATE/TIME: 13 JUN 1985 1300 SOURCE: DIR WARD: 3S TYPE CODE: DTS
PNT CATEGORY: ACT-DUTY USAF BRANCH OF SERVICE: F
GRADE: 02 LENGTH OF SVC: YRS: 09 MOS: MIL SPEC: 0086 FLY STATUS: 1R
MARITAL STATUS: M SEX: M RACE: C DOB: 09 SEP 1952
RELIGION: ROMAN CATHOLIC
AERO RATING: NO RATING OR DESIGNATION AVIATION SERVICE CODE: 1R

DISPOSITION: DATE/TIME: 20 JUN 1985 1200 TYPE: DUTY
UNDERLYING CAUSE: FACILITY TFR TO:

SELECTED ADMINISTRATIVE DATA:

CAUSE OF INJURY:

SPONSOR NAME: DERRICK,JAKE
DUTY ADDRESS:
ALEXANDRIA VA 22312

NXT OF KIN RELATIONSHIP: WIFE EMERGENCY RELATIONSHIP:
NAME: DERRICK,JUDY NAME:
ADDRESS: ADDRESS:
ALEXANDRIA VA 22312

PATIENT
ADDRESS: HOME PHONE:
ALEXANDRIA VA 22312 WORK PHONE:
PRIMARY MTF:

========== D I A G N O S E S ==========

ICD: 0029 INF:
PARATYPHOID FEVER, NOS

ICD: 2705 INF:
DISTURBANCES OF HISTIDINE METABOLISM

========== P R O C E D U R E S ==========

PROCEDURE: 8732- - DATES: 13 JUN 1985
CONTROLLED ATELECTASIS
PROVIDER TEAM: CLIFF BARNES

PROCEDURE: 8172- - DATES: 14 JUN 1985
SYRINGING OF MIDDLE EAR
PROVIDER TEAM: STAFF

========== N O N - P R O C E D U R A L P R O V I D E R S ==========

PRIMARY PROVIDER: CLIFF BARNES

CONTINUED ON PAGE 2

** REPLACES AF FORM 565 **

RECORD OF INPATIENT TREATMENT (RIPT) (AIR FORCE)

RUN DATE: 24 JUN 1985 **** RECORD OF INPATIENT TREATMENT **** PAGE: 2
TIME: 1542 PERSONAL DATA - PRIVACY ACT OF 1974
MTF: 0654

*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****

REGISTER: 0000321 NAME: DERRICK,JAKE FMP/SSN: 20 313-90-8283

========== E P I S O D E D A Y S U M M A R Y ==========

*TOT DAYS	BED DAYS	NON-BED DAYS *	
			THIS MTF: 0654
			ADMIT DATE: 13 JUN 1985 1300 DISP DATE: 20 JUN 1985 1200
7			INTERNAL MEDICINE
	7	0	BED OCCUPANT THIS MTF
			DATE ASSIGNED: 13 JUN 1985
====	====	====	
7	7	0	*TOTAL DAYS THIS MTF
0	0	0	*TOTAL PRIOR MTFS, NON-MILITARY FACILITIES AND TRANSIT
7	7	0	*TOTAL DAYS TO DATE

CONVALESCENT LEAVE TAKEN: 0 RECOMMENDED:

========== O T H E R R E S O U R C E S ==========

CC-WHOLE BLOOD	CC-PACKED CELLS	PRE-OP DAYS	POST-OP DAYS	COOPERATIVE CARE DAYS THIS MTF	COOPERATIVE CARE DAYS PRIOR MTFS	SUPP CARE DAYS THIS MTF	SUPP CARE DAYS PRIOR MTFS
				0	0	0	0

REGISTER: 0000321 NAME: DERRICK,JAKE FMP/SSN: 20 313 90-8283

>>>>>>> END OF REPORT >>>>>>>

** REPLACES AF FORM 565 **

RECORD OF INPATIENT TREATMENT (RIPT) (AIR FORCE)

RUN DATE: 24 JUN 1985 **** RECORD OF INPATIENT TREATMENT **** PAGE: 1
TIME: 1604 PERSONAL DATA - PRIVACY ACT OF 1974
MTF: 00168

*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****

REGISTER: 0000220 NAME: FISHER,LINDA FMP/SSN: 30 241-83-7623

ADMISSION: DATE/TIME: 12 JUN 1985 1300 SOURCE: DIR WARD: 3S TYPE CARE: DIS
PNT CATEGORY: DEPN USN ACTIVE DUTY BRANCH OF SERVICE: N
CIV OCC:
MARITAL STATUS: M SEX: F RACE: C DOB: 09 AUG 1954
RELIGION: LUTHERAN
RECORDS RECEIVED: HR- DR- SR- PR- ORD- PF-

DISPOSITION: DATE/TIME: 15 JUN 1985 0900 TYPE: HOME
UNDERLYING CAUSE: FACILITY TFR TO:

SELECTED ADMINISTRATIVE DATA:

CAUSE OF INJURY:

NXT OF KIN RELATIONSHIP: HUSBAND EMERGENCY RELATIONSHIP: MOTHER
NAME: FISHER,FRANK NAME: WALKER,EVE
ADDRESS: 13 WALTON WAY ADDRESS: 132 STONE ST
ALEXANDRIA VA 22312 BETHESDA ME 20910

PATIENT
ADDRESS: 13 WALTON WAY HOME PHONE:
ALEXANDRIA VA 22312 WORK PHONE:
PRIMARY MTF:

========== D I A G N O S E S ==========

OCCUPATION RELATED: N FPTE: ICD: 0058 CAUSE:
FOOD POISONING,BACTERIAL NEC

OCCUPATION RELATED: FPTE: ICD: 0071 CAUSE:
GIARDIASIS

========== P R O C E D U R E S ==========

PROCEDURE: 1760- - DATES: 13 JUN 1985
BASAL METABOLIC RATE TESTS
PROVIDER TEAM: STAFF DOCTOR

PROCEDURE: 1636- - DATES: 13 JUN 1985
DUODENOSCOPY
PROVIDER TEAM: STAFF DOCTOR

========== N O N - P R O C E D U R A L P R O V I D E R S ==========

PRIMARY PROVIDER: STAFF DOCTOR

CONTINUED ON PAGE 2

RECORD OF INPATIENT TREATMENT (RIPT) (NAVY)

RUN DATE: 24 JUN 1985 **** RECORD OF INPATIENT TREATMENT **** PAGE: 2
TIME: 1604 PERSONAL DATA - PRIVACY ACT OF 1974
MTF: 00168

*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****DRAFT*****

REGISTER: 0000220 NAME: FISHER,LINDA FMP/SSN: 30 241-83-7623

EPISODE DAY SUMMARY

*TOT DAYS	BED DAYS	NON-BED DAYS *	
			THIS MTF: 00168
			ADMIT DATE: 12 JUN 1985 1300 DISP DATE: 15 JUN 1985 0900
3			INTERNAL MEDICINE
	3	0	BED OCCUPANT THIS MTF
			DATE ASSIGNED: 12 JUN 1985
3	3	0	*TOTAL DAYS THIS MTF
0	0	0	*TOTAL PRIOR MTFS, NON-MILITARY FACILITIES AND TRANSIT
3	3	0	*TOTAL DAYS TO DATE

CONVALESCENT LEAVE TAKEN: 0 RECOMMENDED:

OTHER RESOURCES

CC-WHOLE BLOOD	CC-PACKED CELLS	PRE-OP DAYS	POST-OP DAYS	COOPERATIVE CARE DAYS THIS MTF	COOPERATIVE CARE DAYS PRIOR MTFS	SUPP CARE DAYS THIS MTF	SUPP CARE DAYS PRIOR MTFS
				0	0	0	0

REGISTER: 0000220 NAME: FISHER,LINDA FMP/SSN: 30 241-83-7623
>>>>>>> END OF REPORT <<<<<<<

RECORD OF INPATIENT TREATMENT (RIPT) (NAVY)

ROSTER OF DELINQUENT RECORDS

a. Definition. This report lists records that have not been completely coded in Clinical Records within the time limit set by the MTF, and which are therefore delinquent. It is requested by the user from the Clinical Records Reports function and is usually printed daily. This report is distributed as determined by the MTF command, and is used to monitor the timeliness of record coding.

b. Format. The header includes the MTF name, the run date, the Privacy Act Statement, the page number, and the report title. The body of the report is arranged in table form, with up to two lines on each patient listed, as described in the Data Chart. Within the report, patients are grouped according to disposition date.

c. Content.

(1) DISPOSITION DATE. Date of disposition. Beneath this date, all patients dispositioned on the date are listed. Disposition dates are shown in the report in the order of earliest to latest.

(2) REG NO. Register number of patient dispositioned on the date above. If more than one patient was dispositioned on that date, they will be listed in ascending register number order.

(3) NAME of patient.

(4) FMP. Patient's family member prefix. Table 1012.

(5) SSN.

(6) DOB.

(7) ATTND PHYS. Patient's primary physician.

(8) WARD. ID of patient's ward.

(9) CLN SVC. Code of clinical service to which patient was assigned. Table 2005.

(10) RECORD - CLERK. Initials associated with the user ID and password of the last user to update the record.

(11) STATUS. The record's Clinical Records status (indicating the stage of CR processing the record is in).

(12) DATE. The date when the record acquired this status.

DATA CHART - ROSTER OF DELINQUENT RECORDS

* * * * * ROSTER OF DELINQUENT RECORDS * * * * *

DISPOSITION DATE / REG NO / EMP	NAME / SSN	DOB	ATTND PHYS	WARD CLN SVC	CLERK	RECORD STATUS	RECORD DATE
	0000032	DAVIS,RICHARD		5F			
	20	000-00-0065	21 APR 1935	STAFF	AAA	HKK	I 11 APR 1985
	0000031	JONES,ROBERT J		4F			
	20	010-01-0121	18 NOV 1945	BLUEJ	AAB		I
	0000033	SMITH,WILLIAM		4W			
	20	001-00-1020	25 DEC 1950	BLUEJ	AAB	HKK	I 11 APR 1985
	0000037	FERNANDEZ,BABY		4W			
	01	333-22-1112	01 APR 1983	BLUEJ	AAB	HKK	I 19 JUN 1985
	0000039	YOUNG,STEVE L		4W			
	20	213 31-4671	19 MAR 1952	BLUEJ	AAD		I
	0000049	RUPERT,MOLLY P		4W			
	20	601-48-8088	01 JAN 1960	BLUEJ	AAA	HKK	I 11 APR 1985
	0000035	FERNANDEZ,MARY		4W			
	30	333-22-1112	18 JAN 1910	BLUEJ	AAA	HKK	R 11 APR 1985
12 APR 1985							
	0000012	JONES,JOHN PAUL		6W			
	20	121-21-2124	04 APR 1944	STAFF	AAA	HKK	W 24 APR 1985
14 APR 1985							
	0000115	VANHORN,JAMES C		7W			
	99	222-77-8899	16 APR 1918	STAFF	AAA	HKK	I 02 MAY 1985
15 APR 1985							
	0000056	WILSON,MARTIN C		2D			
	20	483-01-1011	18 NOV 1956	BLUEJ	AAA	HKK	I 15 APR 1985
	0000057	MILLER,MICHAEL K		2D			
	20	501-51-5050	02 JAN 1960	BLUEJ	AAA	HKK	I 15 APR 1985
16 APR 1985							
	0000062	MAVIS,RICHARD		2D			
	20	100-00-0065	21 APR 1935	BLUEJ	AAA	HKK	S 16 APR 1985
17 APR 1985							
	0000017	PARTON,FREDDY		2R			
	30	999-99-9999	08 SEP 1954	STAFF	AAA	HKK	I 28 MAY 1985

Appendix D

QUALITY ASSURANCE INPUTS AND OUTPUTS

Part 1. QUALITY ASSURANCE INPUTS (SCREENS)

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INTRODUCTION TO PART 1

Part 1 of this Appendix contains examples of screens used by the Quality Assurance subsystem, which consists of the Quality Assurance and Profiling functions. Each screen which contains data fields is followed by a Data Chart describing those fields, and giving the number of the table in which possible entries can be found. Maximum field length is specified for any fields in which you can enter data. Fields where you are required to enter data are indicated by ** after the description of the field.

Common Data Fields. The following patient identification data appears on several QA screens. It is described in detail here rather than on each QA Data Chart.

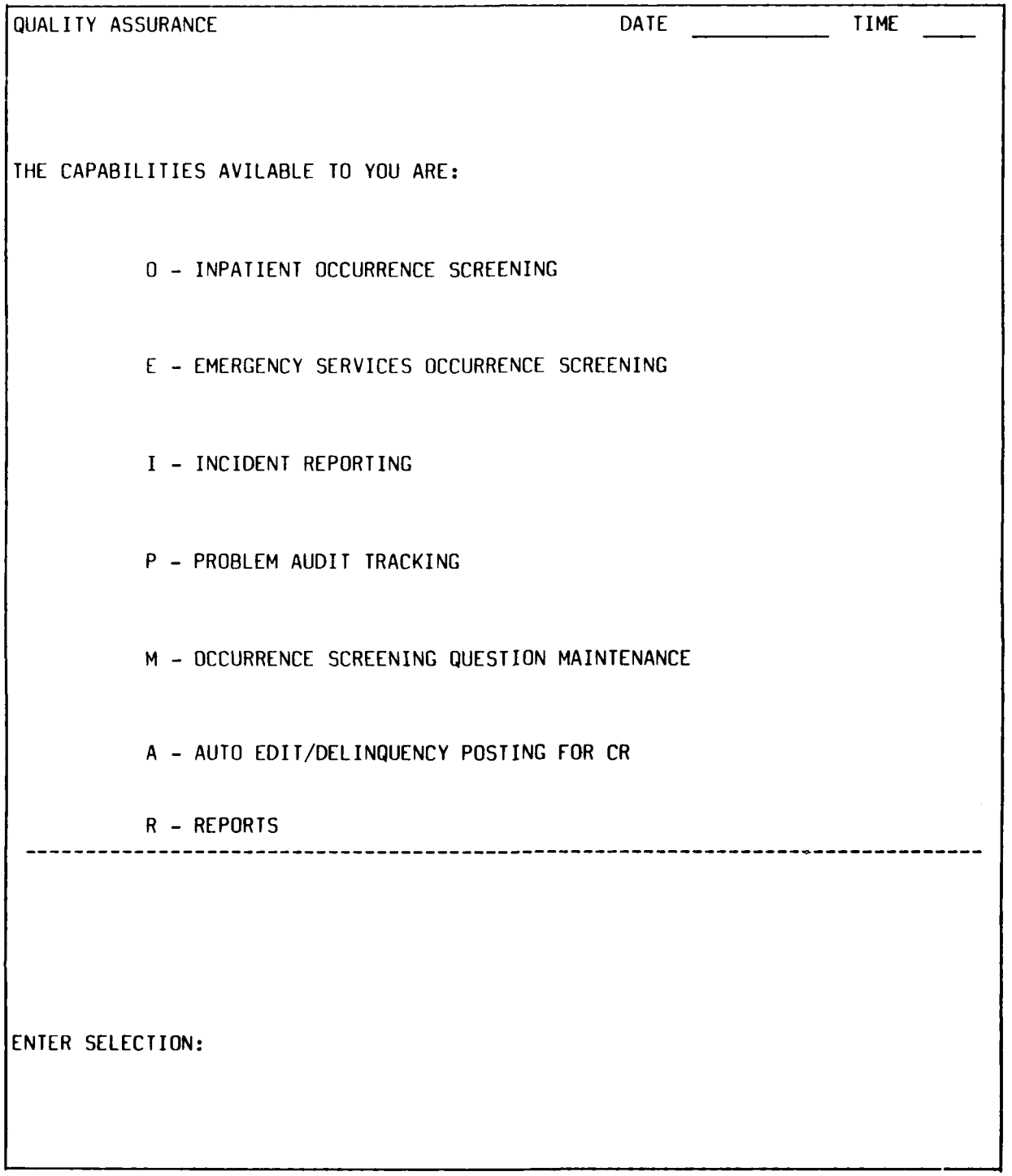
(1) PATIENT NAME. Name of the patient, in the following format: last name followed by comma, followed immediately by first name. First name can be followed by a space and a middle initial or middle name, and/or a space and a title. Last name can contain hyphens or an apostrophe, but no other punctuation; first name and middle name can contain hyphens but no other punctuation.

(2) FMP. Patient's family member prefix. An FMP of 20 means that the patient is a sponsor. If the patient is not a sponsor, FMP indicates the relationship of the patient to the sponsor. See Table 1012 for codes.

(3) SSN. Social Security Number of patient's sponsor (or of patient if patient is the sponsor).

(4) REGISTER NUMBER. 7-digit number assigned to the inpatient episode during admission. For Air Force newborns, the mother's register number is used, followed by a 1-letter alphabetical suffix--i.e., A for a single birth or for the first of a multiple birth, B for the second of a multiple birth, etc.

BASIC DATA CHART
Showing Data Common to AQCESS QA Screens



QUALITY ASSURANCE MENU SCREEN

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

INPATIENT OCCURRENCE SCREENING CHECKLIST

REG NO _____

QA - INPATIENT OCCURRENCE ID SCREEN

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

INPATIENT OCCURRENCE SCREENING CHECKLIST

REG NO _____ NAME _____ FMP __ SSN _____

DISC DATE _____ PROVIDER: PRIM _____ SPEC _____ DATE ENTD _____

NBR	DESCRIPTION	Y/N
#1	ADMISSION FOR CONDITION WHICH MAY REPRESENT COMPLICATION OF PREVIOUS OUTPATIENT TREATMENT	_
#2	READMISSION WITHIN 6 MONTHS FOR CONDITION WHICH IS POSSIBLY A COMPLICATION OF PREVIOUS TREATMENT	_
#3	DRUG OR TRANSFUSION REACTION	_
#4	UNEXPECTED TRANSFER FROM GENERAL CARE BED TO SPECIAL CARE BED	_

---

1 - NEXT PAGE 2 - PREVIOUS PAGE 3 - PERFORM AUDIT

ENTER SELECTION: _

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

QA - INPATIENT OCCURRENCE SCREENING CHECKLIST (page 1)

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

INPATIENT OCCURRENCE SCREENING CHECKLIST

REG NO _____ NAME _____ FMP __ SSN _____

DISC DATE _____ PROVIDER: PRIM _____ SPEC _____ DATE ENTD _____

NBR	DESCRIPTION	Y/N
#5	UNANTICIPATED TRANSFER TO ANOTHER ACUTE CARE FACILITY	_
#6	CARDIAC OR RESPIRATORY ARREST	_
#7	ORGAN FAILURE (HEART, KIDNEY, LUNG, BRAIN) NOT PRESENT ON ADMISSION	_
#8	DEATH	_
#9	NEUROSENSORY OR FUNCTIONAL DEFICIT OR INTRACTABLE PAIN NOT PRESENT ON ADMISSION	_

---

1 - NEXT PAGE 2 - PREVIOUS PAGE 3 - PERFORM AUDIT

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

QA - INPATIENT OCCURRENCE SCREENING CHECKLIST (page 2)

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

INPATIENT OCCURRENCE SCREENING CHECKLIST

REG NO _____ NAME _____ FMP __ SSN _____

DISC DATE _____ PROVIDER: PRIM _____ SPEC _____ DATE ENTD _____

NBR	DESCRIPTION	Y/N
#10	APGAR SCORE OF 4 OR LESS AT ONE MINUTE OR 7 OR LESS AT 5 MINUTES	_
#11	INJURY OF ORGAN/BODY PART DURING INVASIVE PROCEDURE (INCLUDING OBSTETRICAL DELIVERY)	_
#12	UNEXPECTED RETURN TO OPERATING ROOM	_
#13	UNPLANNED REMOVAL OR REPAIR OF NORMAL BODY PART DURING SURGERY (NOT DOCUMENTED ON THE INFORMED CONSENT)	_

---

1 - NEXT PAGE 2 - PREVIOUS PAGE 3 - PERFORM AUDIT

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

QA - INPATIENT OCCURRENCE SCREENING CHECKLIST (page 3)

```
QUALITY ASSURANCE                                    DATE _____ TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974

                  INPATIENT OCCURRENCE SCREENING CHECKLIST

REG NO _______ NAME _____________________________ FMP __ SSN _________

DISC DATE _________ PROVIDER: PRIM _____ SPEC _____ DATE ENTD _________

NBR   DESCRIPTION                                                    Y/N

#14   POST OPERATION COMPLICATION                                     _

#15   ACUTE MI OR CVA AFTER SURGERY                                   _

#16   OPERATION FOR REMOVAL OF FOREIGN BODY LEFT IN OPERATION SITE    _

#17   REPEAT OF SAME INVASIVE PROCEDURE DURING THE SAME ADMISSION     _

#18   DISCHARGE AGAINST MEDICAL ADVICE                                _

 ----------------------------------------------------------------------

      1 - NEXT PAGE          2 - PREVIOUS PAGE          3 - PERFORM AUDIT

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --
```

QA - INPATIENT OCCURRENCE SCREENING CHECKLIST (page 4)

All of the information displayed on the Inpatient Occurrence Checklist Screens is defaulted by the system. You will only be able to update the primary provider's clinical specialty and the responses to the checklist items. No other fields can be updated.

(1) REG NO. Register number of the inpatient episode being screened.

(2) NAME, FMP, SSN. See the Basic Data Chart.

(3) DISCHARGE DATE. Date when the patient was dispositioned, ending this inpatient episode.

(4) PROVIDER: PRIM. Short name of patient's primary care provider. Defaulted from the name of the primary provider entered on the Clinical Records Miscellaneous Screen. If this episode has not been called up in Clinical Records yet, this field defaults to the name of the attending physician entered in Admission. Table 1004.

(7) SPEC. UCA code for primary provider's medical specialty. If provider has more than one specialty, enter the one applicable to this case. Table 1004. Up to 4 characters available.

(8) DATE ENTERED. Date on which this checklist was filled out.

(9) NBR. Number of the question on the checklist.

(10) DESCRIPTION. Text of the occurrence screening question. Questions 1 through 18 are mandatory for each MTF; questions specific to the individual MTF can be entered as items 19 through 24. See Data Chart for Question Maintenance Screen.

(11) Y/N. Field in which yes or no answer is entered. All questions will default to "no" unless certain questions are defaulted to "yes" by Clinical Records data. When the checklist is first accessed for a patient, you must move the cursor through the response field for each question. If any response has been defaulted to "yes," you cannot change it. These fields must contain a Y or N; no response field can be blank.

DATA CHART - QA, INPATIENT OCCURRENCE SCREENING CHECKLIST

```
1  QUALITY ASSURANCE                                    DATE _____ TIME ____
2                      PERSONAL DATA - PRIVACY ACT OF 1974
3                   INPATIENT OCCURRENCE SCREENING CHECKLIST
4  REG NO _____ NAME _____ FMP __ SSN _____
5  DISC DATE _____ PROVIDER: PRIM _____ SPEC _____ DATE ENTD _____
6
7  NBR   DESCRIPTION
8  #__   _____
9        _____
10
11 REVIEW LEVEL     DATE OUT        DATE DUE       DATE IN        ACTION CODE
12      #1          _____           _____          _____          _ _ _ _
13      #2          _____           _____          _____          _ _ _ _
14      #3          _____           _____          _____          _ _ _ _
15
16 VARIATIONS POSTED TO PROVIDERS: ____ ____ ____ ____ ____
17           PROVIDERS' SPECIALTY: ___ ___ ___ ___ ___
18  ----------------------------------------------------------------------
19
20
21 ENTER SELECTION:
22
23 -- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --
24
```

QA - INPATIENT SCREENING AUDIT

When this screen appears, it displays the patient data already entered, and number and description of the first checklist question that was answered affirmatively.

(1) REG NO, NAME, FMP, SSN. See the Basic Data Chart.

(2) DISC DATE. Date of disposition for this inpatient episode.

(4) PROVIDER: PRIM. Short name of primary provider. Table 1004.

(5) SPEC. Primary provider's clinical specialty that applies to this case. Table 1004.

(6) DATE ENTD. Date when the checklist for this patient was filled out.

(7) NBR. Number of the question that had an affirmative answer.

(8) DESCRIPTION. Text of the question that had an affirmative answer.

(9) REVIEW LEVEL. Number of the review. Up to 3 are possible.

(10) DATE OUT. Date on which the case was assigned to a reviewer. 11 characters.

(11) DATE DUE. Date by which the review should be completed and returned. 11 characters.

(12) DATE IN. Date on which the completed review was returned. 11 characters.

(13) ACTION CODE. 4 1-character codes are entered for each review level.

- 1st code - indicates the job classification of the person or name of committee that the review was assigned to. Table 6054.
- 2nd code - indicates whether the case involved the patient's provider (1 = provider involved; 2 = not involved).
- 3rd code - indicates the result of the review. Table 6055.
- 4th code - indicates whether this variation is to be posted to the provider's profile (Y/N).

(14) VARIATIONS POSTED TO PROVIDERS. When the fourth action code is "Y" the variation will be posted to the profile of the provider whose short name you enter here. You can enter names of up to 5 providers. If the validated occurrence or death has already been posted, the provider name(s) will be displayed. You can update these names or add additional providers as a result of subsequent reviews. You can only enter the name of each provider once. Up to 6 characters for each name. Table 1004.

DATA CHART - QA, INPATIENT SCREENING AUDIT

(15) PROVIDERS' SPECIALTY. Specialty of each provider to which this variation will be posted. If provider has more than one specialty, this will be the specialty that applies to this particular case. Table 2005. Up to 4 characters available.

DATA CHART - QA, INPATIENT SCREENING AUDIT

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

ER LOG NO _____

PATIENT NAME _____

FAMILY MEMBER PREFIX (FMP) __

SPONSOR'S SOCIAL SECURITY NUMBER (SSN) _____

(N = NEW) SELECTION _

NAME FRAGMENT SEARCH ENTER PATIENT'S NAME ONLY

SOCIAL SECURITY NUMBER SEARCH SSN IS REQUIRED/FMP IS OPTIONAL

QA - EMERGENCY SERVICE PTID SCREEN

(1) ER LOG NO. Number of the Emergency Room episode. To locate the record of an existing episode directly, enter its log number in this field. 7 characters.

(2) PATIENT NAME, FAMILY MEMBER PREFIX, SPONSOR'S SOCIAL SECURITY NUMBER. See the Basic Data Chart. (Name can be up to 30 characters long, FMP is 2 characters, SSN is 9 digits with punctuation optional.)

DATA CHART - QA, EMERGENCY SERVICE PTID SCREEN

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

LIST	NAME OF PATIENT	FMP	SSN
0	_____	__	_____
1	_____	__	_____
2	_____	__	_____
3	_____	__	_____
4	_____	__	_____
5	_____	__	_____
6	_____	__	_____
7	_____	__	_____
8	_____	__	_____
9	_____	__	_____

[0 - _] PATIENT SELECTED N - VIEW NEXT PAGE

ENTER SELECTION:

QA - EMERGENCY SERVICE CANDIDATE LIST SCREEN

This data is for display only. You cannot enter or update data in any of the following fields.

(1) LIST. Number of the episode on the Candidate List. Enter the number of the candidate whose record you want to process in the SELECTION field.

(2) NAME OF PATIENT, FMP, SSN. See the Basic Data Chart.

DATA CHART - QA, EMERGENCY SERVICE CANDIDATE LIST SCREEN

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME: _____ SSN: _____ FMP: __

LIST	ER LOG NBR	DATE OF TREATMENT	PROVIDER
0	_____	_____	_____
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____

[0 - _] PATIENTS SELECTED N - VIEW NEXT PAGE

R - CREATE NEW ER EPISODE

ENTER SELECTION:

QA - EMERGENCY SERVICE EPISODE LIST SCREEN

This screen is for display only. You cannot enter or update data in any of the following fields.

(1) NAME, SSN, FMP of the patient who has been treated in the Emergency Room more than once. See the Basic Data Chart.

(2) LIST. The sequence number of the patient's Emergency Room visit. Enter the list number of the visit you are interested in in the SELECTION field.

(3) ER LOG NBR. Number of the Emergency Room episode. 7 characters.

(4) DATE OF TREATMENT. Date of the Emergency Room visit.

(5) PROVIDER. Short name of the provider who treated the patient during the visit.

DATA CHART - QA, EMERGENCY SERVICE EPISODE LIST SCREEN

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

PATIENT NAME _____ FMP __ SSN _____

ER LOG NO _____ DATE/TIME OF TREATMENT _____ PRVDR ID _____

NBR	DESCRIPTION	Y/N
#1	PATIENT SEEN IN ER WHO HAS EITHER BEEN DISCHARGED OR SEEN IN ER WITHIN THE PAST 48 HOURS	_
#2	PATIENT NOT SEEN BY PHYSICIAN	_
#3	PATIENT ARRIVES DOA OR DIES IN THE ER	_
#4	PATIENT LEAVES WITHOUT BEING SEEN OR LEAVES AGAINST MEDICAL ADVICE	_

---

1 - NEXT PAGE 2 - PREVIOUS PAGE 3 - PERFORM AUDIT

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

QA - EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST (page 1)

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

PATIENT NAME _____ FMP __ SSN _____

ER LOG NO _____ DATE/TIME OF TREATMENT _____ PRVDR ID _____

NBR	DESCRIPTION	Y/N
#5	UNEXPECTED ABNORMAL DIAGNOSTIC TEST RESULTS (E.G., LAB, XRAY, EKG) RETURNED TO ER AFTER PATIENT HAS BEEN RELEASED	_
#6	MEDICATION ERROR/REACTION	_
#7	CARDIAC ARREST/RESPIRATORY ARREST	_

---

1 - NEXT PAGE 2 - PREVIOUS PAGE 3 - PERFORM AUDIT

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

QA - EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST (page 2)

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

PATIENT NAME _____ FMP __ SSN _____

ER LOG NO _____ DATE/TIME OF TREATMENT _____ PRVDR ID _____

NBR	DESCRIPTION	Y/N
#8	PATIENT RELEASED FROM ER WITHOUT DOCUMENTATION OF INSTRUCTIONS AND DISPOSITION IN THE RECORD	_
#9	SUSPECTED SPOUSE/CHILD/SEXUAL ABUSE WITHOUT REPORTING/FOLLOWUP ACTIONS DOCUMENTED IN THE RECORD	_

---

1 - NEXT PAGE 2 - PREVIOUS PAGE 3 - PERFORM AUDIT

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

QA - EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST (page 3)

This screen displays patient data that was entered on the Emergency Service PTID Screen.

(1) PATIENT NAME, FMP, SSN. As entered on the Emergency Service PTID Screen. Defaulted by the system but can be overridden.

(2) ER LOG NO. Number assigned to this Emergency Room episode. The MTF can have log numbers assigned automatically by the system or manually by you, as specified on the MTF Profile in System Management. If numbers are being assigned automatically, a number will appear in this field when you first call up this screen. You can override the automatically assigned log number the first time you access this screen for the episode but not after you have already filled out the Emergency Service checklist. If log numbers are being assigned manually, enter a log number in this field when you first access this screen for an Emergency Room episode. **

(3) DATE/TIME OF TREATMENT, PRVDR ID. Enter both the date and time of treatment and the short name of the provider (Table 1004). **

(4) NBR. The number of the checklist item.

(5) DESCRIPTION. Text of the checklist item. Questions 1 through 9 are mandatory for all MTFs. Questions specific to a particular MTF can be entered as items 10 through 24. See Data Chart for Question Maintenance Screen.

(6) Y/N. Response to the checklist item. Defaulted to "no" when this screen is first accessed for an Emergency Room episode, except that the first question can be defaulted to "yes" from data entered elsewhere in the system. You can change the "no" defaults to "yes," but cannot change a "yes" response to "no." These fields must contain a response; they cannot be blank.

DATA CHART - QA, EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

PATIENT NAME _____ FMP __ SSN _____

ER LOG NO _____ DATE/TIME OF TREATMENT _____ PRVDR ID _____

NBR DESCRIPTION

#__ _____

_____

REVIEW LEVEL	DATE OUT	DATE DUE	DATE IN	ACTION CODE
#1	_____	_____	_____	_ _ _ _
#2	_____	_____	_____	_ _ _ _
#3	_____	_____	_____	_ _ _ _

VARIATIONS POSTED TO PROVIDERS: ____ ____ ____ ____ ____

PROVIDERS' SPECIALTY: ____ ____ ____ ____ ____

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

QA - EMERGENCY SERVICE SCREENING AUDIT

(1) PATIENT NAME, FMP, SSN. See the Basic Data Chart.

(2) ER LOG NO, DATE/TIME OF TREATMENT, PRVDR ID. See the Data Chart for the Emergency Services Occurrence Screening Checklist.

(3) NBR, DESCRIPTION, REVIEW LEVEL, DATE OUT, DATE DUE, DATE IN, ACTION CODE, VARIATIONS POSTED TO PROVIDERS, PROVIDER'S SPECIALTY. See the Data Chart for the Inpatient Screening Audit.

DATA CHART - QA, EMERGENCY SERVICE SCREENING AUDIT

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

INCIDENT REPORT

LOG NO _____

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

QA - INCIDENT ID SCREEN

(1) LOG NO. Enter the number that identifies the incident you are interested in. You can only access existing data on an incident by entering its log number. If data on this incident has not yet been entered on the system, enter NEW to access a blank Incident Log Screen.

DATA CHART - QA, INCIDENT ID SCREEN

```
1  QUALITY ASSURANCE                                DATE _____ TIME ____
2                    PERSONAL DATA - PRIVACY ACT OF 1974
3                              INCIDENT REPORT
4  LOG NO ______
5  DATE/TIME OF INCIDENT _____________
6  PERSON INVOLVED  TYPE _____________ NAME _____________________________
7                                      FMP __  SSN _____________ REG NO _____
8  TYPE OF INCIDENT _____________________
9  LOCATION OF INCIDENT _____________________________
10 PERSONNEL INVOLVED _____________________ PERSONNEL REPORTING _____________
11 RESULT OF INCIDENT  _
12
13 DATE REVIEWED BY RISK MANAGER _________
14 JAG REVIEW _                             DATE SENT TO JAG _________
15 DATE OF ACTION _________                  ACTION CODE _ _ _
16 DATE OF ACTION _________                  ACTION CODE _ _ _
17 DATE OF ACTION _________                  ACTION CODE _ _ _
18 ------------------------------------------------------------------------
19
20
21 ENTER SELECTION:
22
23 -- A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --
24
```

QA - INCIDENT LOG SCREEN

(1) LOG NO. Number that identifies the incident, assigned by the system.

(2) DATE/TIME OF INCIDENT. Date and time when incident occurred. 11 characters. **

(3) PERSON INVOLVED: TYPE. The type of person involved in the incident (e.g., patient, visitor). Enter a 1-character code from Table 6050, or enter more than one code separated by commas, or free text enclosed in single quotes. Up to 15 characters allowed. **

(4) NAME of the person involved. 27 characters allowed. **

(5) FMP of person involved. 2 characters.

(6) SSN of person involved. 11 characters allowed.

(7) REG NO. of person involved. 8 characters. **Required for inpatients.**

(8) TYPE OF INCIDENT. For example, a fall. You can enter up to 20 characters of free text enclosed in single quotes, or you can enter one or more 1-character codes from Table 6051, separated by commas. **

(9) LOCATION OF INCIDENT. Enter one or more 1-character codes from Table 6052, separated by commas; or enter up to 25 characters of free text enclosed in single quotes.

(10) PERSONNEL INVOLVED. The type of MTF personnel involved in the incident (i.e., job classification). Enter one or more 1-character codes from Table 6053, or up to 15 characters of free text enclosed in single quotes.

(11) PERSONNEL REPORTING. Code for the type of MTF personnel reporting the incident. Enter one or more 1-character codes from Table 6053, or up to 15 characters of free text enclosed in single quotes.

(12) RESULT OF INCIDENT. Indicates whether injury resulted from this incident. Y/N. **

(13) DATE REVIEWED BY RISK MANAGER. 11 characters.

(14) JAG REVIEW. 1-character code for whether this incident will be reviewed by the Judge Advocate General. (Yes/No.)

(15) DATE SENT TO JAG. Date when record of this incident was sent to the Judge Advocate General's office. 11 characters.

DATA CHART - QA, INCIDENT LOG SCREEN

(16) DATE OF ACTION taken regarding this incident. 11 characters.

(17) ACTION CODE. 3 1-character codes can be entered for each action. (A 4th action code, which is used on the Inpatient Screening Audit, is not used on this screen--that is, no incidents are posted to providers.)

1st code - indicates the job classification of the person or committee that the review was assigned to. Table 6054.
2nd code - indicates whether the case involved the patient's provider (1 = provider involved; 2 = not involved).
3rd code - indicates the result of the review. Table 6055.

DATA CHART - QA, INCIDENT LOG SCREEN

```
1  QUALITY ASSURANCE                                DATE _____ TIME ____
2                    PERSONAL DATA - PRIVACY ACT OF 1974
3                                PROBLEM AUDIT
4  PROBLEM NO _____
5
6
7
8
9
10
11
12
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14
15
16
17
18
19
20
21
22
23 -- A MEDICAL QA DOCUMENT.  DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --
24
```

QA - PROBLEM ID SCREEN

(1) PROBLEM NO. Enter the number that identifies the problem you are interested in. You can only access existing data on a problem by entering its problem number. If data on this incident has not yet been entered on the system, enter NEW to access a blank Problem Audit Screen.

DATA CHART - QA, PROBLEM ID SCREEN

QUALITY ASSURANCE DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

PROBLEM AUDIT

PROBLEM NO _____ RESOLVED FLAG _

DATE PRESENTED _____ REFERRAL ACTIVITY _____

IMPACT ON PATIENT CARE

_____

_____

ACTION ACTIVITY _____ STATUS DATE _____

ACTION TAKEN

_____

FOLLOWUP DATE _____

---

1 - UPDATE PROBLEM STATUS 2 - PREVIOUS STATUS 3 - NEXT STATUS

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

QA - PROBLEM AUDIT SCREEN

(1) PROBLEM NO. Number that identifies this problem, assigned by the system.

(2) RESOLVED FLAG. Indicates whether this problem has been resolved (Y/N). **Required when you initially enter data on the problem.**

(3) DATE PRESENTED. Date on which the problem was presented. 11 characters. **Required when you initially enter data on the problem.**

(4) REFERRAL ACTIVITY. The person or area of the hospital reporting the problem (e.g., a particular nurses' station). 15 characters of free text available. **Required when you initially enter data on the problem.**

(5) IMPACT ON PATIENT CARE. 2 lines of free text available, 78 characters on each. **Required when you initially enter data on the problem.**

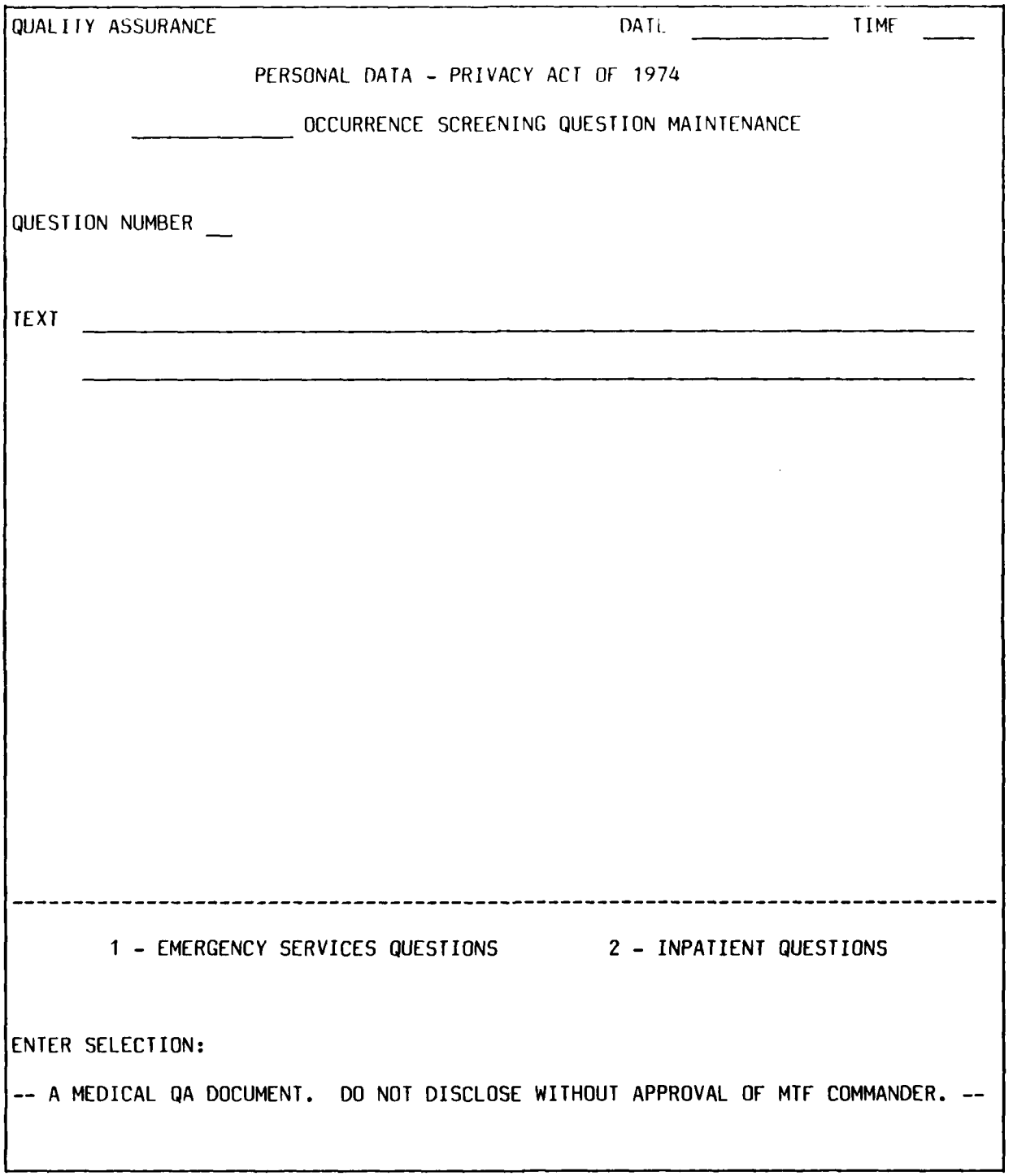
(6) ACTION ACTIVITY. The person or group who took the action that is being described on this screen. 15 characters of free text available. **Required when entering data on the problem.**

(7) STATUS DATE. The effective date of the information entered on this screen. When you enter new status data on this problem, the status date cannot be earlier than the previous date entered in this field. 11 characters. **Required when entering data on the problem.**

(8) ACTION TAKEN. The action taken on the problem. 2 lines available for free text, 70 characters in each. **Required when entering data on the problem.**

(9) FOLLOWUP DATE. Date on which any followup activity occurred. 11 characters.

DATA CHART - QA, PROBLEM AUDIT SCREEN



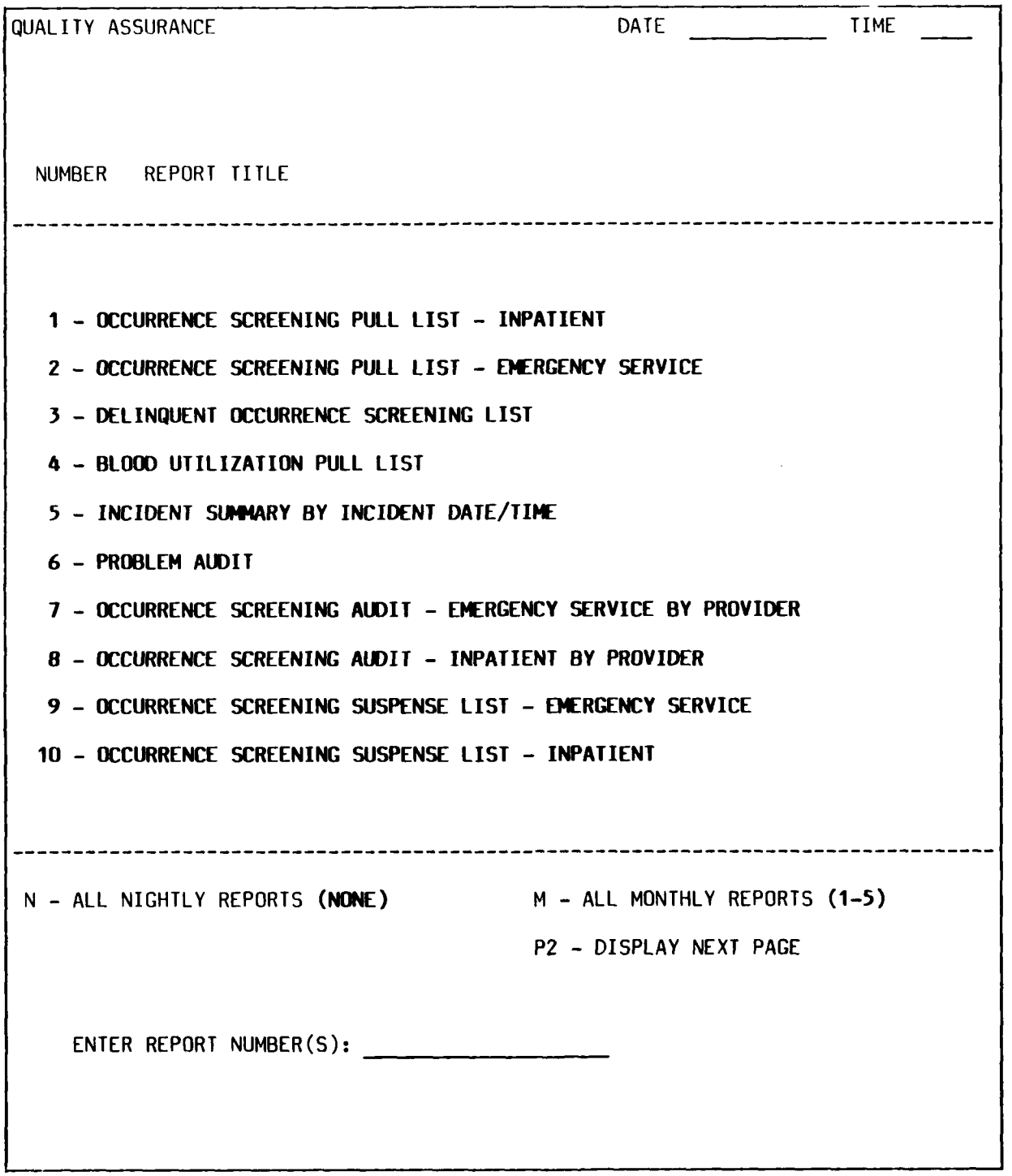
QA - OCCURRENCE SCREENING QUESTION MAINTENANCE SCREEN

UH007

(1) QUESTION NUMBER. The number of an existing MTF-specific Occurrence Screening checklist question that is to be changed, or of a new question to be added to the MTF-specific questions (numbers 19 through 24 for Inpatient Occurrence Screening, and numbers 10 through 24 for Emergency Services Occurrence Screening). If the user updates or replaces an MTF-specific question, the user must indicate whether data entered under the old question should be cleared from the system.

(2) TEXT of the question to be changed or added. 2 lines of free text available, with 68 characters on each line.

DATA CHART - QA, OCCURRENCE SCREENING QUESTION MAINTENANCE SCREEN



QA - REPORTS SCREEN

UH007

BLOOD UTILIZATION PULL LIST DATE _____ TIME ____

RUN-TIME INFORMATION

PERIOD START _____

PERIOD END _____

PRINTER COPIES ___

SELECTION __

QA - RUN-TIME INFORMATION SCREEN FOR THE BLOOD UTILIZATION PULL LIST

The Run-Time Information Screen displays different fields, or parameters, for each report. All screens contain a PRINTER COPIES field; many allow you to specify the report period, which is period of time for which you want data. You must enter a date in any fields that ask you to specify the report period.

(1) PERIOD START. First day of the report period. **

(2) PERIOD END. Last day of the report period. **

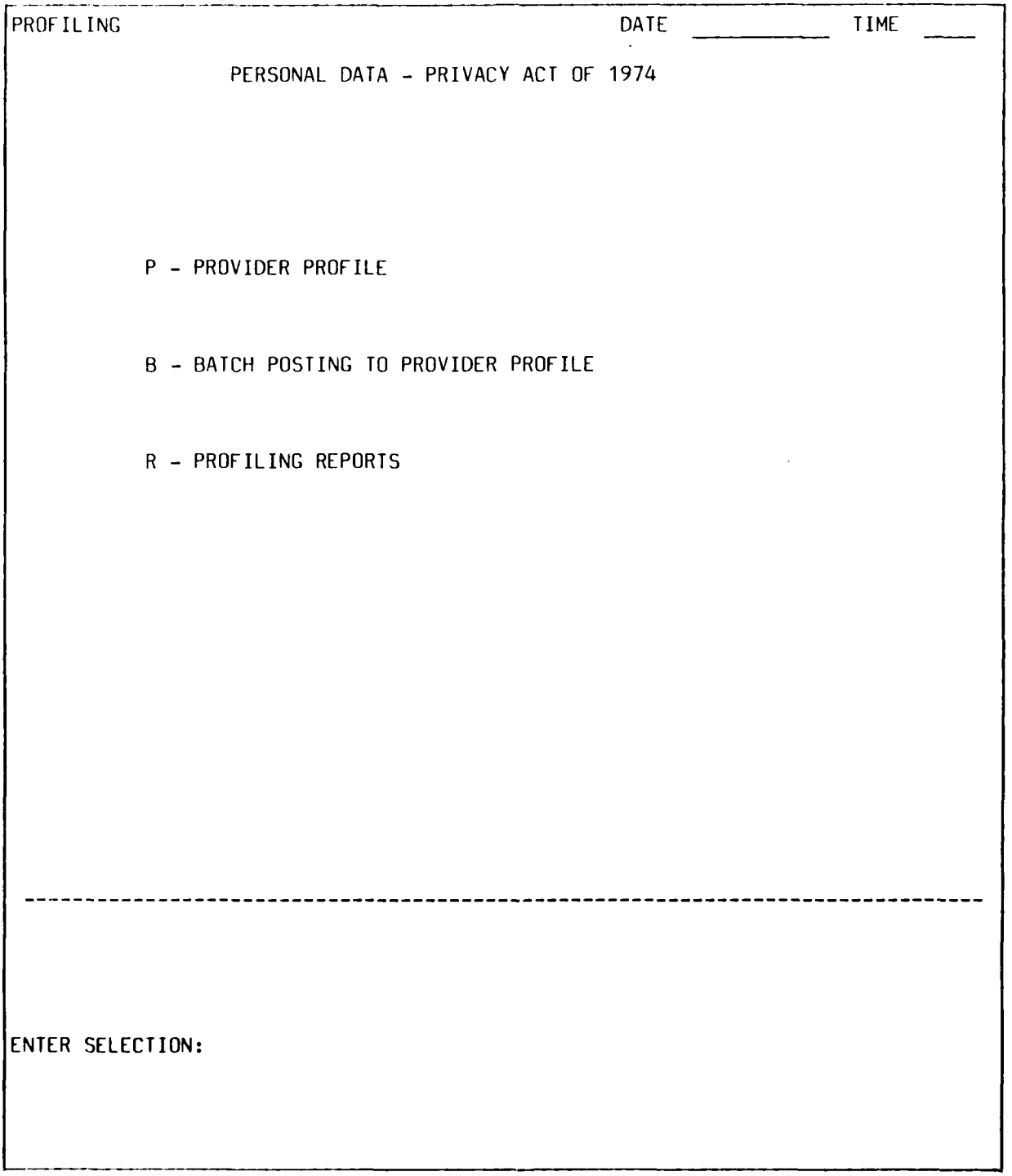
(For example, if you enter a PERIOD START of 01 JUN 85, and a PERIOD END of JUN 15 85, the Blood Utilization Pull List will consist of data on all blood utilization at the MTF between these dates.)

(3) PRINTER COPIES. Number of copies you want run. Entries you can make in this field are listed below.

- If you leave this field blank, the report will be displayed at your terminal instead of being printed.
- If you enter R, the last report run will be displayed at your terminal.
- If you enter a number, that many copies of the report will be printed.
- If you enter R and a number (e.g., R3), the last report run will be printed as many times as you indicate.

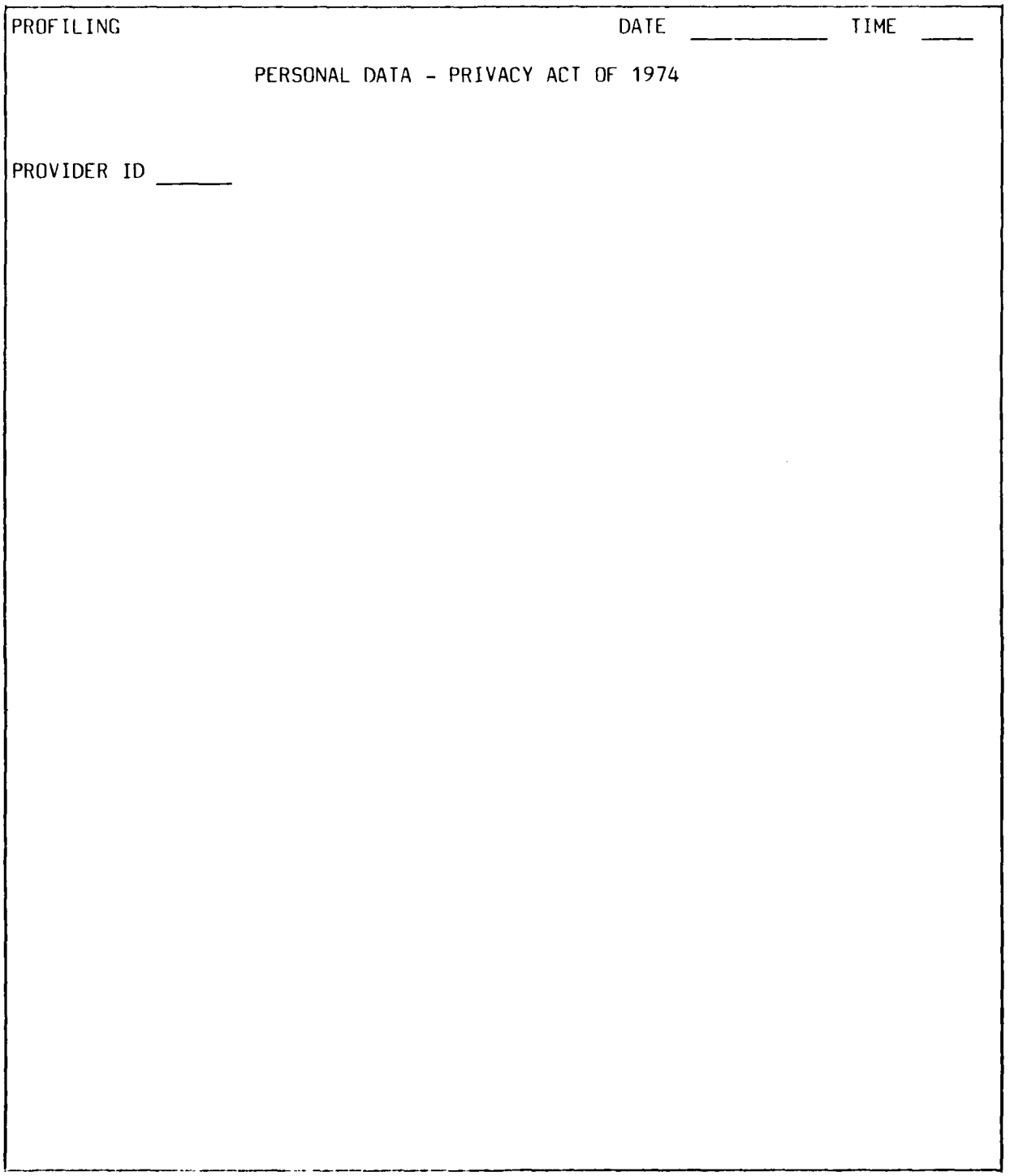
The SELECTION field on this screen operates in the same way as the ENTER SELECTION field on any other screen. You can enter all or part of the parameter label to return to that field and update it.

DATA CHART - RUN-TIME INFORMATION SCREEN



PROFILING MENU

UH007



PROFILING - PROVIDER ID SCREEN

(1) PROVIDER ID. Enter the short name or the QA ID code of the provider whose profile you wish to update or enter. Up to 9 characters. Table 1004 or any valid QA ID code.

DATA CHART - PROFILING, PROVIDER ID SCREEN

```
PROFILING                                          DATE ___________  TIME ____

                    PERSONAL DATA - PRIVACY ACT OF 1974


PROVIDER ID ______  NAME ___________________________  SPEC ________________

QA ID CODE __________  CONT ED (YY/HH)  __/__ __/__ __/__  ASGN DTE ________

DATE OF:  CPR TRAINING __________  ACLS CERT __________  ATLS CERT __________

          CREDENTIALS RENEWAL __________

          LICENSE RENEWAL     __________     STATE OF LICENSE __


---- CLINICAL INDICATOR TOTALS FOR A MONTH PERIOD BEGINNING ______________----

PROCEDURES PERFORMED ______        PATIENTS DISCHARGED      ______

MALPRACTICE CLAIMS FILED ______    MED RECORD DEFICIENCIES  ______

                                   MED RECORD DELINQUENCIES ______

VALIDATED:  ANTIBIOTIC VARIATIONS ______   COMPLAINTS    ______

            NORMAL SURGICAL TISSUE ______  TRANSFUSIONS  ______

            SCREENING VARIATIONS   ______  TOTAL DEATHS  ___

-------------------------------------------------------------------------------


    1 - PREVIOUS 6 MONTH PERIOD       2 - NEXT 6 MONTH PERIOD


ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --
```

PROFILING - PROVIDER PROFILE SCREEN

Note: all date fields are 11 characters long.

(1) PROVIDER ID. Short version of the doctor's name. Table 1004. For display only; you cannot update.

(2) PROVIDER NAME. Last name, first name, middle initial. Table 1004. For display only.

(3) SPEC. Specialty list of the provider, e.g., "ACA; ACB." Codes from specialty field in Table 1004. For display only.

(4) QA ID CODE. ID code of the provider. Used to identify provider on QA reports. For display only.

(5) CONT ED (YY/HH). The continuing education credit hours completed by this provider for the last three years. The current year is displayed first, followed by the previous year, then the year before that. In the HH field, enter or update the number of credit hours earned in the year indicated.

(6) ASGN DTE. Date on which the provider was assigned to this MTF. For display only.

(7) DATE OF: CPR TRAINING. Date on which the provider completed train- in cardiopulmonary resuscitation (CPR).

(8) ACLS CERT. Date on which the provider was certified in Advanced Trauma Life Support (ATLS).

(9) ATLS CERT. Date on which the provider was certified in Advanced Cardiac Life Support (ACLS).

(10) CREDENTIALS RENEWAL. Date on which the provider's credentials for this MTF are due to be renewed by the Credentials Committee.

(11) LICENSE RENEWAL. Date on which the provider's license to practice is due to be renewed by the state licensing board.

(12) STATE OF LICENSE. 2-character abbreviation. Table 1015.

(13) CLINICAL INDICATOR TOTALS FOR 6 MONTH PERIOD BEGINNING (date). The data on this screen is accumulated for the six-month period beginning on this date.

DATA CHART - PROFILING, PROVIDER PROFILE SCREEN

(14) PROCEDURES PERFORMED. Number of procedures performed by this provider. Calculated from Clinical Records data after the CR record was approved. For display only.

(15) PATIENTS DISCHARGED. Number of patients dispositioned with this physician as the attending/primary provider. Calculated from CR data after the CR record was approved. For display only.

(16) MALPRACTICE CLAIMS FILED. Enter the number of claims filed against this provider. Up to 6 digits.

(17) MED REC DEFICIENCIES. Enter the number of medical records considered deficient because this provider had not supplied parts of the chart (e.g., history/physical, signatures, etc.) by the time the record was accessed Clinical Records. Up to 6 digits.

(18) MED RECORD DELINQUENCIES. Number of medical records considered delinquent because this provider had not completed missing chart items within the time limit set by the MTF. Calculated from CR data when option A on the QA Menu Screen is selected.

(19) VALIDATED: ANTIBIOTIC VARIATIONS. Enter the number of occurrences related to antibiotic use for which the provider has received a "failed" audit result. Up to 6 digits.

(20) COMPLAINTS. Enter the number of validated patient complaints lodged against this provider. Up to 6 digits.

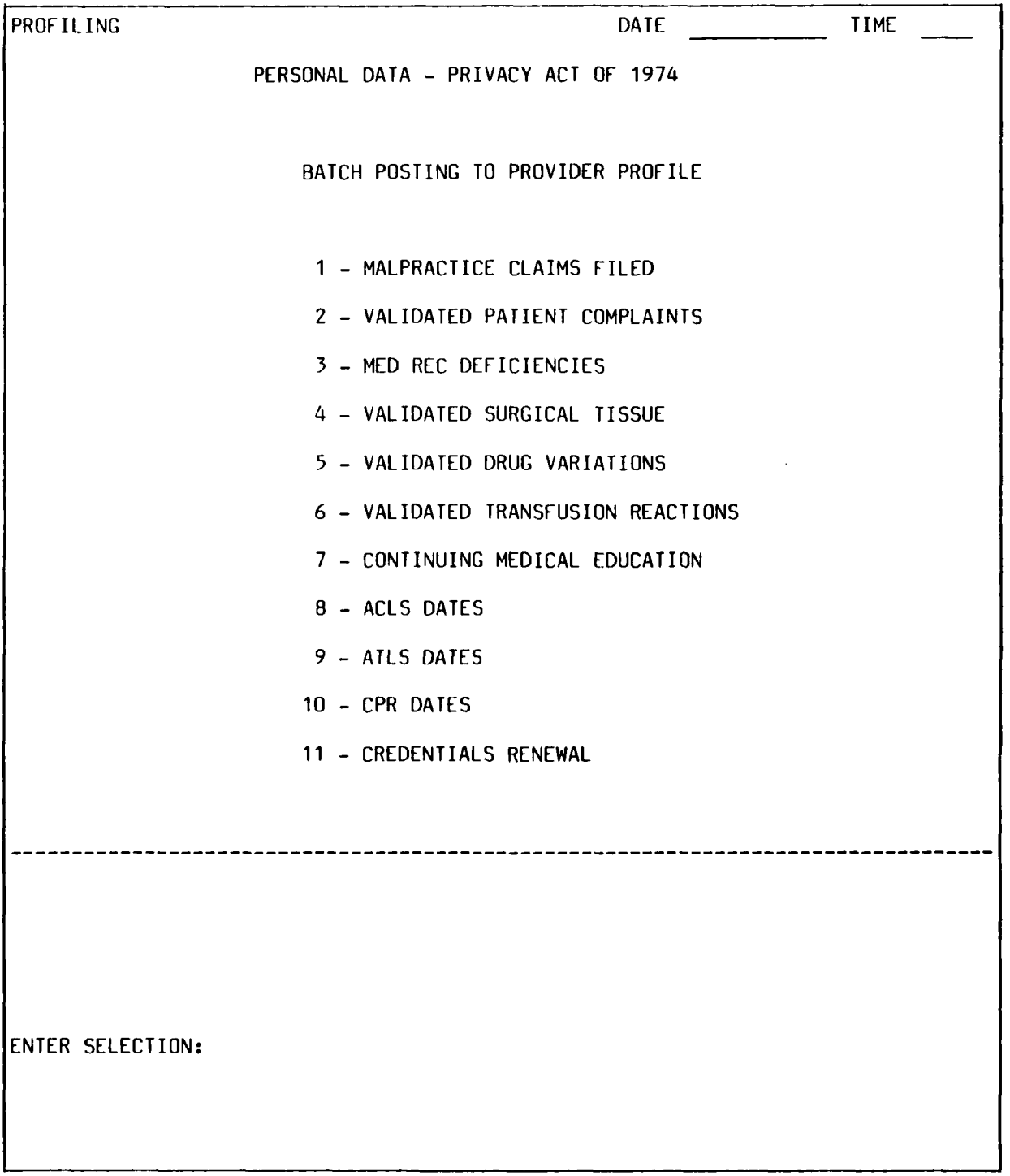
(21) NORMAL SURGICAL TISSUE. Enter the number of occurrences related to normal surgical tissue, for which the provider has received a "failed" audit result. Up to 6 digits.

(22) TRANSFUSIONS. Enter the number of occurrences related to transfusions, for which the provider has received a "failed" audit result. Up to 6 digits.

(23) SCREENING VARIATIONS. Number of occurrences for this provider that have been posted automatically as a result of Inpatient and Emergency Service reviews.

(24) TOTAL DEATHS. Number of patient deaths that the audit process has indicated should be posted to this provider profile. Posted automatically as a result of Inpatient and Emergency Services reviews.

DATA CHART - PROFILING, PROVIDER PROFILE SCREEN



PROFILING - BATCH POSTING MENU SCREEN

UH007

PROFILING DATE _____ TIME ____

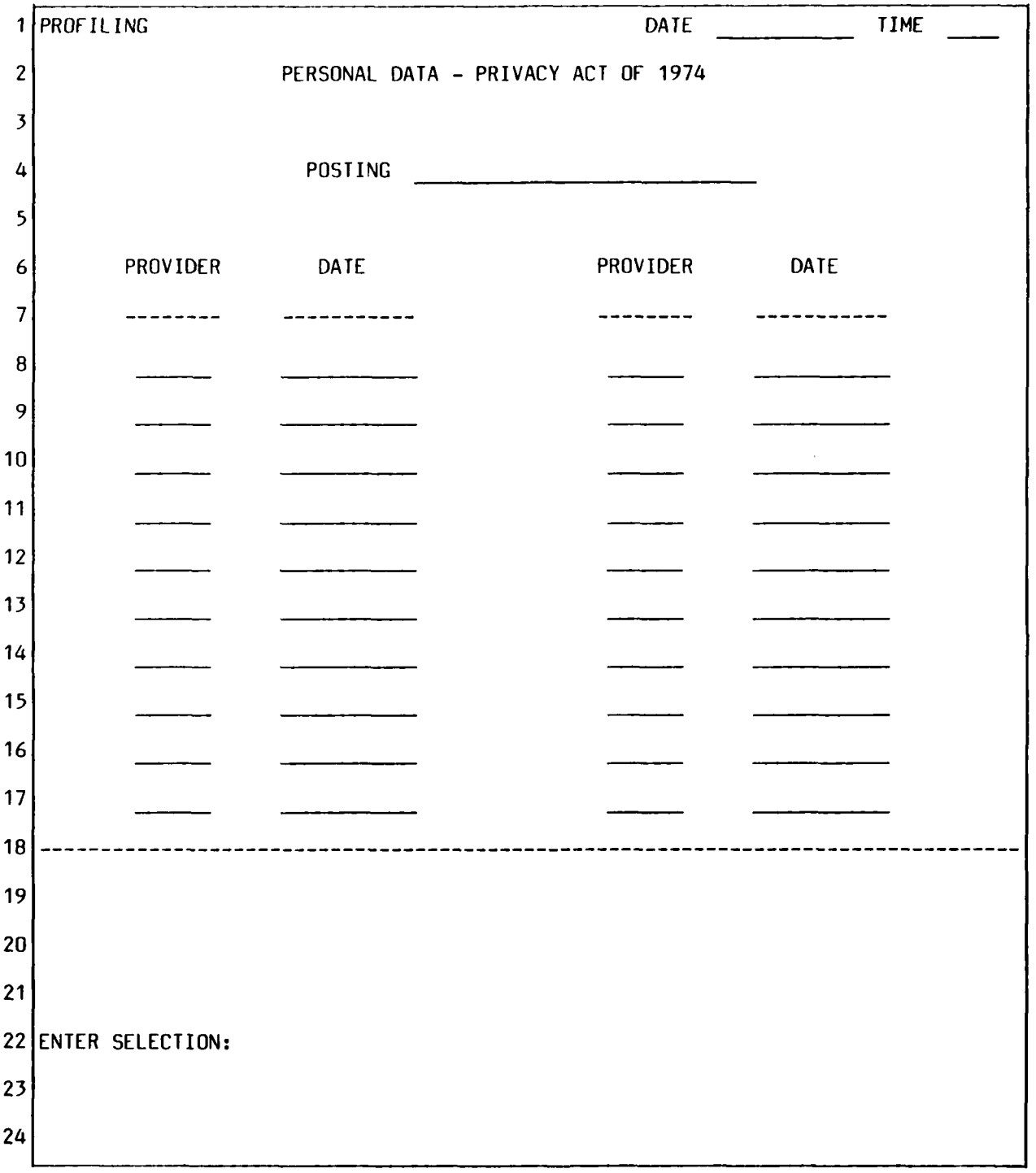
PERSONAL DATA - PRIVACY ACT OF 1974

POSTING _____ EFFECTIVE DATE _____

PROVIDER	QTY	EFF DATE	PROVIDER	QTY	EFF DATE
---	---	---	---	---	---

ENTER SELECTION:

PROFILING - BATCH POSTING SCREEN (Options 1-7)



PROFILING - BATCH POSTING SCREEN (Options 8-11)

(1) POSTING. The type of posting that you selected from the Batch Posting Menu Screen is displayed automatically in this field.

(2) EFFECTIVE DATE. This field appears on the Posting Screen for the first 7 options. It refers to the effective date for the update.

(3) PROVIDER. Name of the provider to whose profile this data is to be posted.

(4) QTY. This field appears on the Posting Screen for the first 7 options. Enter the number of events (e.g., malpractice claims) that you want posted to this provider profile.

(5) DATE or EFF DATE. Effective date of this update. On the Posting Screen for the first 7 options, if you do not enter a date here, this field will default to the date entered in item (2) above.

DATA CHART - PROFILING, BATCH POSTING SCREENS

REPORT SELECTION AND RUN-TIME INFORMATION SCREENS

The Profiling function uses a Report Selection Screen, listing the available Profiling reports, and a Run-Time Information Screen for each report. These screens look the same for Profiling as they do for the Quality Assurance function (except that they list different reports). For a description of the data on the Profiling Run-Time Information Screen, see the Data Chart for the Quality Assurance Run-Time Information Screen.

Part 2. QUALITY ASSURANCE OUTPUTS (REPORTS)

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INTRODUCTION TO PART 2

This Part presents the outputs of the QA subsystem, with those produced by the QA function first, followed by the outputs of the Profiling function. The descriptions of outputs are organized as follows:

a. Definition - a brief description of the report, its purpose or function, frequency of production, and utilization.

   Reports generated by the Quality Assurance function are requested by the user using the Reports option on the Quality Assurance Menu. Reports generated by the Profiling function are requested by the user using the Reports option on the Profiling Menu.

b. Format - the organization of the output's contents, and any header data it might include. All QA reports include a trailer saying, "A medical document. Do not release without approval of the MTF commander."

c. Content - a Data Chart describing each of the output's data items.

d. Example - a sample of each output.

BLOOD UTILIZATION PULL LIST

a. Definition. The Blood Utilization Pull List summarizes blood product utilization, by care provider, over a period of time that is specified by the person requesting the report. It includes data on patients dispositioned within that time period who received blood.

The Blood Utilization Pull list can be run monthly or on request. It is distributed to the Lab, to Quality Assurance, and to the professional services. It is used to list records that are to undergo quality control review by the Blood Utilization Review Committee.

b. Format. The header for this report gives the MTF name, the run date (the day when the report was printed), the report title, and the period for which it is effective. The body of the report is in the form of a table, containing the data listed below.

c. Content.

(1) PROVIDER. The 9-digit QA ID code for the health care provider who ordered the blood product.

(2) REG NO. Register number of the patient to whom blood was administered.

(3) FMP. Family member prefix of the patient. Table 1012.

(4) SSN. Social Security Number of the patient or the patient's sponsor.

(5) DISCHARGE DATE. Date on which this patient was discharged.

DATA CHART - BLOOD UTILIZATION PULL LIST

TEST AFB RUN DATE: 07 JUN 1985

BLOOD UTILIZATION PULL LIST
PERIOD: 08 MAY 1985 THRU 07 JUN 1985

PROVIDER	REG NO	FMP	SSN	DISCHARGE DATE
472724626	0000094	20	495-09-3421	10 MAY 1985 1100
472724626	0000099	20	234-55-0987	15 MAY 1985 0830
769687696	0000044	20	301-00-1111	10 MAY 1985 0910
453534535	0000159	20	444-44-4444	14 MAY 1985 1406
999999999	0000053	20	123-00-4444	13 MAY 1985 1400
999999999	0000104	20	189-42-0802	10 MAY 1985 0400
999999999	0000140	20	223-21-7801	13 MAY 1985 1100
999999999	0000227	20	568-58-2637	17 MAY 1985 1352

A MEDICAL QA DOCUMENT. DO NOT RELEASE WITHOUT APPROVAL OF MTF COMMANDER

DELINQUENT OCCURRENCE SCREENING LIST

a. Definition. This report lists each inpatient whose Occurrence Screening Checklist is not completed within the period of time after disposition designated by the MTF. (The amount of time before delinquency is specified on the MTF Profile in System Management.) A checklist is not considered complete until it has been compared with an approved Clinical Record. This report can be run monthly or on request. It is distributed to Clinical Records, MTF command, and the professional services.

b. Format. The header for the Delinquent Occurrence Screening List contains the name of the MTF, the run date, and the report title. The body of the report is in table form, consisting of the data described below.

c. Content.

(1) DISCHARGE DATE. The patient's date and time of disposition.

(2) REG NO. Register number of the patient.

(3) FMP. Family member prefix of the patient. Table 1012.

(4) SSN. Social Security Number of the patient or the patient's sponsor.

DATA CHART - DELINQUENT OCCURRENCE SCREENING LIST

NH PORTSMOUTH, VA RUN DATE: 11 JUL 1985

DELINQUENT OCCURRENCE SCREENING LIST

DISCHARGE DATE	REG NO	EMP	SSN
25 MAR 1985 1600	0000001	20	111-11-1111
15 APR 1985 1200	0000003	20	333-33-3333
06 MAY 1985 1200	0000052	20	444-44-4444
15 JUN 1985 1800	0000007	20	101-01-0101
20 JUN 1985 1200	0000002	20	888-88-8888
30 JUN 1985 1900	0000006	20	999-99-9999

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DIAGNOSIS INDEX BY PROVIDER

a. Definition. This report gives information on diagnoses entered in Clinical Records, by provider of care. It lists patient deaths, and patients whose length of stay was outside of the range considered normal for the diagnosis. For a record to be included on the report, the patient must have been dispositioned within the time period specified by the user, and the record must have been approved in Clinical Records or already submitted to higher command (CR status of A or T). The user can specify the name of the doctor, or leave that field blank to request a report on all providers (in that case data on each provider will begin on a new page).

b. Format. The header for this report includes the name of the report, the provider, and the MTF. The date on the right is the ending date specified by the user. The report data, described below, is in table form.

c. Content.

The first line, ALL DIAGNOSIS, gives totals for all diagnoses on this proder's cases (e.g., the total variations for the provider).

(1) ICDA CODE. ICD code for the diagnosis. Table 9001.

(2) DIAGNOSIS TITLE. Description of the diagnosis. Also from Table 9001.

(3) CASES. The TOTAL column shows the total number of cases with this diagnosis. The PRIM column shows the number of cases for which this diagnosis was the primary diagnosis entered in Clinical Records. The TRF column shows how many of these cases transferred into the MTF.

(4) VARIATIONS. The TOT column shows the total number of variations found for cases with this diagnosis. The DTHS column shows the total number of deaths that occurred among patients with this diagnosis. The COMP column shows the total number of complications occurring among patients with this diagnosis. The INF column shows the number of infection codes entered for cases with this diagnosis. The LOS shows the number of patients with this diagnosis who had excess lengths of stay at this MTF.

(5) LENGTH OF STAY. These columns show the average range of stay for patients with this diagnosis, as contained in the ICD Table (Table 9001). The ACTIVE DUTY RANGE field shows the average range of stay for active-duty patients. The OTHER RANGE field shows the average range of stay for other than active-duty patients.

DATA CHART - DIAGNOSIS INDEX BY PROVIDER

(6) PERCENT EXCESS LOS. The percentage of patients with this diagnosis whose lengths of stay exceeded the ranges shown in field (5).

The next line of data gives the following information for any individual death or length-of-stay variation occurring among patients with this diagnosis.

(7) REG NO.

(8) DETH. Indicates whether this patient died.

(9) COMP. Indicates whether any complications were recorded for this patient.

(10) INF. Indicates whether any infections were recorded for this patient.

(11) LOS. The number of days that this patient's length of stay was outside of the normal range for this diagnosis.

(12) BENF. The beneficiary category of this patient.

(13) ALL DIAGNOSES. The ICD code and description of the diagnosis.

(14) OPERATIONS. The ICP code and description of any procedures performed on this patient during the inpatient episode.

(15) OPR. Indicates whether this provider was listed for this procedure as the primary provider, the assistant provider, or the teaching or other assistant.

DATA CHART - DIAGNOSIS INDEX BY PROVIDER

PREPARED 16 SEP 1985
QUARTERLY

INDIVIDUAL MEDICAL RECORDS INPATIENT REPORTING
DIAGNOSIS INDEX BY PROVIDER OF CARE
JOHNS, MIKE
TEST NAVY MTF

AS OF 85 SEP 15
PART B

ICDA CODE	DIAGNOSIS TITLE	**** CASES **** TOTAL	PRIM	TRF	****** VARIATION ***** TOT	DTHS	COMP	INF	LOS	***** LENGTH OF STAY **** ACTIVE DUTY RANGE		OTHER RANGE		PERCENT EXCESS LOS
	ALL DIAGNOSIS	3	3	0	1	0	0	0	1					33.3
5410	APPENDICITIS, UNQUALIFIED	2	2		1				1	1-20	0.0	1-8	9.5	50.0

REG NO	DTH	COMP	INF	LOS	BENF	ALL DIAGNOSES	OPERATIONS	OPR
6482				16	0	5410 APPENDICITIS, UNQUALIFIED	5470 APPENDECTOMY	P

5311	GASTRIC ULCER, ACUTE WITH PERFORATION	1	1								21.0		0.0	

DISPOSITIONS BY DIAGNOSIS REPORT

a. Definition. This report lists all diagnoses of patients who were discharged from the MTF during the reporting period specified by the user. To be included on the Dispositions by Diagnosis Report a record must have been accessed, but not necessarily approved, in Clinical Records. This report is printed on demand.

b. Format. The header for this report includes the report name and the MTF name. The date on the right is the end date for the reporting period. The body of the report is arranged in table form, and contains the data described below.

c. Content.

(1) DIAGNOSIS. The CODE field shows the code for this diagnosis. The TITLE field shows its descriptive title. Table 9001.

(2) ALL DIAGNOSES. These fields show the age ranges of patients having this diagnosis, whether this was the primary diagnosis for these patients or not. UNDER 28D = under 28 days; 1M - 13Y = 1 month to 13 years old; 14Y - 64Y = 14 years to 64 years old; etc.

(3) TOTAL. The total number of patients who had each diagnosis.

(4) PERSONNEL CATEGORY. The personnel category of the patients having the indicated diagnosis as their primary diagnosis. AD = Air Force, Army, or Navy active duty; OTH AD = other active duty; MIL DPN = military dependent; ALL OTH = others.

(5) DISP TYPE. These fields show the disposition type entered for patients who had the indicated diagnosis as their primary diagnosis. TSFER = disposition type of transfer; OTHER = other disposition types.

(6) BED DAYS THIS MTF. These fields show the number of bed days at this MTF for patients having the indicated diagnosis as their primary diagnosis. TOTAL = total number of bed days; TSFER CASES = number of bed days accumulated by transfers-in; ALL OTHER = shows the number of bed days accumulated by patients who did not transfer in.

(7) BLOOD TRANSFUSED. The amount blood transfused for patients who had the indicated diagnosis as their primary diagnosis.

DATA CHART - DISPOSITIONS BY DIAGNOSIS REPORT

UH007

DISPOSITIONS BY DIAGNOSIS REPORT

D-2-10

PREPARED 04 SEP 1985 INDIVIDUAL MEDICAL RECORDS INPATIENT REPORTING AS OF 85 SEP 04
QUARTERLY DISPOSITION BY DIAGNOSIS PART 5
TEST NAVY MTF

DIAGNOSIS CODE	TITLE	ALL DIAGNOSES AGE UNDER 28D	1M - 13Y	14Y - 64Y	OVER 65	TOTAL	PRIMARY DIAGNOSES PERSONNEL CATEGORY NAVY AD	OTH AD	MIL DPN	MIL RET	ALL OTH	DISP TYPE TSFER	OTHER	BED DAYS THIS MTF TOTAL	TSFER CASES	ALL OTHER	BLOOD TRANS FUSED
2001	LYMPHOSARCOMA			1		1	1						1	9		9	
4151	PULMONARY EMBOLISM			1		1	1						1	1		1	
5000	COALWORKERS' PNEUMOCONIOS			1		1			1				1	5		5	1000
42290	ACUTE MYOCARDITIS, UNSPEC			1		1	1						1	2		2	

INCIDENT SUMMARY

a. Definition. The Incident Summary gives information about all incidents that occurred at the MTF during the time period specified by the user. It can be produced monthly or on request, and its distribution is command determined.

b. Format. The header for this summary contains the MTF name, the run date, the report title, and the starting and ending dates of the reporting period. The body of the report is in table form, with up to three lines of data about each incident.

c. Content.

(1) INCIDENT DATE/TIME. Date on which the incident occurred. This date must fall within the reporting time period for the data on this incident to be included on the report.

(2) LOG #. The log number assigned to the record of the incident.

(3) INJURY. Indicates whether an injury resulted from this incident.

(4) ACTION 1. This field contains up to 3 1-character action codes that describe the first action that might have been taken on this incident. These codes are as follows:

1st code - indicates the job classification of the person or committee that the review was assigned to. Table 6054.
2nd code - indicates whether the case involved the patient's provider (1 = provider involved; 2 = not involved).
3rd code - indicates the result of the review. Table 6055.

(5) ACTION 2 and ACTION 3. These fields contain the action codes that describe the second and third actions that might have been taken on this incident. See item (6) for description of these codes.

(6) JAG REVIEW. This field indicates whether this incident was submitted to the Judge Advocate General for review.

(7) TYPE PERSON INVOLVED. The type of person involved in the incident. Table 6050. Up to 3 listed.

(8) TYPE INCIDENT. The nature of the incident, e.g., a fall. Table 6051. Up to 3 listed.

DATA CHART - INCIDENT SUMMARY

(9) LOCATION OF INCIDENT. Up to 3 listed.

(10) CATEGORY OF PERSONNEL REPORTING. The type of MTF personnel reporting the incident. Table 6053. Up to 3 listed.

(11) CATEGORY OF PERSONNEL INVOLVED. The type of MTF personnel involved in the incident. Table 6053. Up to 3 listed.

DATA CHART - INCIDENT SUMMARY

INCIDENT SUMMARY

FROM INCIDENT DATE 01 JUN 1985 THRU 30 JUN 1985

INCIDENT TYPE PERSON INVOLVED	DATE/TIME TYPE INCIDENT	LOG #	INJURY	ACTION 1 LOCATION OF INCIDENT	ACTION 2 CATEGORY OF REPORTING	ACTION 3 PERSONNEL INVOLVED	JAG REVIEW
VISITOR	04 JUN 1985 ALTERCATION	38	Y	M2 4E HALLWAY	L2 NURSE PRACTI	CORPSMAN	
INPATIENT	12 JUN 1985 1900 FALL	44	Y	F2 STAIRWAY	L2 HOUSEKEEPING		
DOCTOR	13 JUN 1985 MEDICATION	41	N				

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

OCCURRENCE SCREENING PULL LIST, INPATIENT AND EMERGENCY SERVICE

a. Description. These reports identify patient records involved in occurrence screening discrepancies, allowing the records to be pulled for review. They contain data on all records that have affirmative responses to the Inpatient or the Emergency Service Occurrence Screening Checklist. The Pull Lists are used in retrospective audits and quality control; their distribution is command determined. They can be printed monthly or on request.

If an Inpatient Occurrence Screening Checklist is entered before the Clinical Record is approved, and the Auto Edit subsequently results in additional affirmative responses, the record will be listed on the Pull List again.

b. Format. The header for these reports contains the name of the MTF, the run date, and the name of the report. The body of the report contains the data described below. Data for the Air Force Inpatient Pull List is sorted by patient name; data for the Army and Navy Inpatient Pull Lists is sorted by SSN. (Because the format for the Inpatient Pull Lists is otherwise the same, only the Navy Pull List is shown.)

c. Content.

(1) FMP. Family member prefix of the patient on whose checklist an affirmative response appears. Table 1012.

(2) SSN. Social Security Number of the patient or the patient's sponsor.

(3) REG NO. Register number for this inpatient episode.

(4) OCCURRENCE CRITERION. The number of the item or items on the Inpatient Occurrence Screening Checklist that was/were answered with "Y."

DATA CHART - OCCURRENCE SCREENING PULL LIST, INPATIENT

(1) LOG NO. Log number assigned to the Emergency Room episode.

(2) FMP/SSN. Family member prefix of the patient (Table 1012) and Social Security Number of the patient or the patient's sponsor.

(3) OCCURRENCE CRITERION. Number of the item or items on the Emergency Service Occurrence Screening Checklist that was/were answered with "Y."

DATA CHART - OCCURRENCE SCREENING PULL LIST, EMERGENCY SERVICES

TEST NAVY MTF RUN DATE: 04 SEP 1985

OCCURRENCE SCREENING PULL LIST

FMP	SSN	REG NO	OCCURRENCE CRITERION
20	333-33-3333	0000003	12
01	202-22-1000	0006460	2
20	182-72-6123	0006461	2,6
20	002-00-2002	0006464	7
20	888-33-3121	0006469	12
20	444-44-4444	0006470	2
30	231-92-8317	0006486	9
20	208-47-3892	0006491	17

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

TRAINING HOSPITAL RUN DATE: 08 JUL 1985

EMERGENCY SERVICE OCCURRENCE SCREENING PULL LIST

LOG NO	EMP/SSN	OCCURRENCE CRITERION
1	20 222-22-2222	1
5	30 333-22-1111	3
1	20 409-84-1575	1
6	01 444-22-9999	4
7	20 888-44-5555	5
8	20 888-77-4444	8

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

OCCURRENCE SCREENING PULL LIST, EMERGENCY SERVICE

UH007

OCCURRENCE SCREENING SUMMARY - FACILITY, INPATIENT AND EMERGENCY SERVICE

a. Definition. These reports summarize the affirmative checklist responses for the time period specified by the user.

Users can request the Inpatient Facility Occurrence Screening Summary in either of two versions: (1) raw data reports, containing data on both validated and unvalidated affirmative answers to checklist questions; and (2) validated data reports, containing information only on validated variations. On the raw data version, checklist data is reported by the specialty of the primary or responsible provider for the case; on the validated version, data is reported by the specialty of the provider that the variation was posted to.

The Inpatient summary includes records that have disposition dates within the reporting period, and that have been approved in Clinical Records. The Emergency Services summary groups data by each individual Emergency Room provider; it includes records (1) if the patient was assigned to the given provider, and (2) if the date of treatment falls within the reporting period. Both reports are produced on request, and their distribution is command determined.

b. Format. Header data for both reports consists of the MTF name, the run date, the report title, and the time period for the report. For Inpatient summaries, the header also indicates whether the report contains raw data or validated data. The body of the reports contains the data described below.

c. Content. The number of each checklist item appears at the top of each page. The Inpatient summary groups data by the provider's specialty, and gives the number of "yes" responses under each checklist item. The Emergency Services summary groups data by individual provider, then gives the number of "yes" responses under each item. Both reports end with the total number of "yes" responses found for this report for the basic checklist items and for the MTF-specific items.

(1) SPEC. The clinical specialty of the provider with relation to the particular case, e.g., internal medicine. Table 2005.

(2) RECORDS. The number of records of patients assigned to this specialty that were screened for this report (see the Definition, above).

(3) TOT OCCS. The total number of affirmative checklist responses found for this group of patients during this time period.

(4) (TOTALS). The end of each report shows the total number of "yes" responses to the basic items on the Inpatient Occurrence Screening Checklist, and the total number of "yes" responses to the Inpatient Checklist items that were devised by the MTF.

DATA CHART - FACILITY OCCURRENCE SCREENING SUMMARY, INPATIENT

TEST NAVY MTF RUN DATE: 16 SEP 1985

FACILITY OCCURRENCE SCREENING SUMMARY
RAW DATA

PERIOD: 01 AUG 1985 THRU 15 SEP 1985

OCCURRENCES BY CRITERION NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0

SPEC: NEUROLOGY
1 RECORDS
2 TOT OCCS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0

SPEC: GYNECOLOGY
1 RECORDS
2 TOT OCCS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0

SPEC: OBSTETRICS
1 RECORDS
1 TOT OCCS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0

SPEC: NURSERY
4 RECORDS
5 TOT OCCS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	2	0	0	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SPEC: PEDIATRIC CARE NEC
2 RECORDS
2 TOT OCCS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

OCCURRENCE SCREENING SUMMARY - FACILITY, INPATIENT (raw data)

TEST NAVY MTF RUN DATE: 16 SEP 1985

FACILITY OCCURRENCE SCREENING SUMMARY
RAW DATA

PERIOD: 01 AUG 1985 THRU 15 SEP 1985

TOTAL OCCURRENCES BY CRITERION NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	2	1	0	0	1	1	0	3	0	0	1	0	2	0	0	1	0	0	0	0	0	0	0

9 TOTAL RECORDS
12 TOT OCCS

1-18 YES: 12
19-24 YES: 0

OCCURRENCE SCREENING SUMMARY - FACILITY, INPATIENT (raw data)

TEST NAVY MTF RUN DATE: 16 SEP 1985

FACILITY OCCURRENCE SCREENING SUMMARY
VALIDATED OCCURRENCES

PERIOD: 01 AUG 1985 THRU 15 SEP 1985

SPEC: INTERNAL MEDICINE
1 RECORDS
1 TOT OCCS

OCCURRENCES BY CRITERION NUMBER																							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SPEC: CARDIOLOGY
1 RECORDS
1 TOT OCCS

OCCURRENCES BY CRITERION NUMBER																							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SPEC: GYNECOLOGY
1 RECORDS
2 TOT OCCS

OCCURRENCES BY CRITERION NUMBER																							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0

SPEC: PEDIATRIC CARE NEC
1 RECORDS
1 TOT OCCS

OCCURRENCES BY CRITERION NUMBER																							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SPEC: PODIATRY
1 RECORDS
1 TOT OCCS

OCCURRENCES BY CRITERION NUMBER																							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SPEC: PSYCHIATRIC CARE
1 RECORDS
1 TOT OCCS

OCCURRENCES BY CRITERION NUMBER																							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

TEST NAVY MTF RUN DATE: 16 SEP 1985

FACILITY OCCURRENCE SCREENING SUMMARY
VALIDATED OCCURRENCES

PERIOD: 01 AUG 1985 THRU 15 SEP 1985

TOTAL OCCURRENCES BY CRITERION NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	3	0	0	0	0	1	0	1	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0

4 TOTAL RECORDS
7 TOT OCCS

1-18 YES: 7
19-24 YES: 0

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

OCCURRENCE SCREENING SUMMARY - FACILITY, INPATIENT (validated data)

(1) PRVDR. On the Emergency Services summary, the QA ID code for the individual provider.

(2) RECORDS. The number of records of patients with this health care provider that were screened for this report (see the Definition for this report).

(3) TOT OCCS. The total number of affirmative checklist responses found for this group of patients during this time period.

(4) (TOTALS). The end of each report shows the total number of "yes" responses to the basic items on the Emergency Service Occurrence Screening Checklist, and the total number of "yes" responses to the ES checklist items that were devised by the MTF.

DATA CHART - FACILITY OCCURRENCE SCREENING SUMMARY, EMERGENCY SERVICE

TEST NAVY MTF RUN DATE: 31 AUG 1985

FACILITY EMERGENCY SERVICE OCCURRENCE SCREENING SUMMARY

PERIOD: 01 AUG 1985 THRU 30 AUG 1985

OCCURRENCES BY CRITERION NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1	0	2	0	1	2	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0

PRVDR: 110112112
3 RECORDS
8 TOT OCCS

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

TEST NAVY MTF RUN DATE: 31 AUG 1985

FACILITY EMERGENCY SERVICE OCCURRENCE SCREENING SUMMARY

PERIOD: 01 AUG 1985 THRU 30 AUG 1985

---------- TOTAL OCCURRENCES BY CRITERION NUMBER ----------

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1	0	2	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

3 TOTAL RECORDS
8 TOT OCCS

1-9 YES: 6
10-24 YES: 2

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

OCCURRENCE SCREENING SUMMARY - PROVIDER, INPATIENT AND EMERGENCY SERVICE

a. Definition. For both inpatients and Emergency Service, the Provider Occurrence Screening Summary summarizes the affirmative checklist responses found for an individual provider for a given reporting period. The individual provider and the time period of the report are specified by the user when the report is requested.

The Inpatient Provider Occurrence Screening Summary also comes in both raw and validated versions. Raw data reports contain data on both validated and unvalidated affirmative answers to checklist questions; validated data reports contain information only on validated variations. The provider on the raw data version is the primary or responsible provider for the case; on the validated version, it is the provider that the variation was posted to.

The Inpatient summary reports on records that have disposition dates falling within the reporting period and that have been approved in Clinical Records. The Emergency Service summary contains data on records that have dates of treatment within the reporting period. Both of these reports are produced on request, and their distribution is command determined.

b. Format. The header of these reports displays the MTF name, the run date, the report title, and whether the report contains raw or validated data, and the reporting period. The body of the reports contains the data described below.

c. Content. For both reports, the first line gives the ID code of the individual provider, the number of patient records screened for the report, and the total number of affirmative responses found on these records. Then each checklist item is listed by number, and below the number, the total number of affirmative responses found for that item for that provider during the reporting period.

TEST NAVY MTF

RUN DATE: 16 SEP 1985

PROVIDER OCCURRENCE SCREENING SUMMARY
RAW DATA

PERIOD: 01 AUG 1985 THRU 15 SEP 1985

PROVIDER: 852257262 RECORDS SCREENED: 1 TOTAL OCCURRENCES: 2

OCCURRENCES BY CRITERION NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

TEST NAVY MTF RUN DATE: 16 SEP 1985

PROVIDER OCCURRENCE SCREENING SUMMARY
VALIDATED OCCURRENCES

PERIOD: 01 AUG 1985 THRU 15 SEP 1985

PROVIDER: 328180391 RECORDS SCREENED: 2 TOTAL OCCURRENCES: 2

OCCURRENCES BY CRITERION NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

OCCURRENCE SCREENING SUMMARY - PROVIDER, INPATIENT (validated data)

TEST AFB RUN DATE: 07 JUN 1985

PROVIDER EMERGENCY SERVICE OCCURRENCE SCREENING SUMMARY

PERIOD: 08 MAY 1985 THRU 07 JUN 1985

PROVIDER: 999999999 RECORDS SCREENED: 1 TOTAL OCCURRENCES: 3

OCCURRENCES BY CRITERION NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

OCCURRENCE SCREENING SUMMARY - PROVIDER, EMERGENCY SERVICE

OCCURRENCE SCREENING SUMMARY - SPECIALTY, INPATIENT

a. Definition. This report summarizes affirmative checklist responses for each provider within a selected clinical specialty. The person requesting the report specifies the specialty and the time period, and chooses either the raw data or validated data version of the report.

Records are included on this report (1) if the primary provider's specialty for this case is the specified specialty, (2) if the disposition date falls within the reporting period, and (3) if the record has been approved in Clinical Records. The Specialty Occurrence Screening Summary is produced when requested, and its distribution is command determined.

b. Format. The report header displays the MTF name, the run date, the report title, and the period of the report. The body of the report contains the data described below.

c. Content. The top of the report lists the Inpatient Occurrence Screening Checklist items by number. Then the report gives the total number of records that were screened and the total number of affirmative checklist responses that were found in these records. The report ends with the number of "yes" responses found for the basic checklist items, and the number found for the MTF-devised items.

TEST NAVY MTF RUN DATE: 16 SEP 1985

SPECIALTY OCCURRENCE SCREENING SUMMARY
RAW DATA

SPECIALTY: PEDIATRIC CARE NEC

PERIOD: 01 AUG 1985 THRU 15 SEP 1985

OCCURRENCES BY CRITERION NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

PRVDR: 328180391
2 RECORDS
2 TOT OCCS

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

TEST NAVY MTF

RUN DATE: 16 SEP 1985

SPECIALTY OCCURRENCE SCREENING SUMMARY
VALIDATED OCCURRENCES

SPECIALTY: GYNECOLOGY

PERIOD: 01 AUG 1985 THRU 15 SEP 1985

OCCURRENCES BY CRITERION NUMBER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0

PRVDR: 852257262
2 RECORDS
2 TOT OCCS

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

OCCURRENCE SCREENING SUMMARY - SPECIALTY, INPATIENT (validated data)

OCCURRENCE SCREENING SUSPENSE LIST, INPATIENT AND EMERGENCY SERVICE

a. Definition. These reports contain data on occurrence screening items that have been assigned for review and have not been returned to the QA office by the date due. These reports are produced on request, and their distribution is determined by the MTF command.

b. Format. The report header displays the MTF name, the run date and time, and the report title. The body of the report contains the data described below.

c. Content.

INPATIENT SUSPENSE LIST

(1) REGISTER NUMBER of the patient whose record shows an open item.

(2) DISCHARGE DATE. The patient's disposition date.

EMERGENCY SERVICE SUSPENSE LIST

(1) FMP/SSN. Family member prefix of the patient whose record shows an open item (Table 1012), and Social Security Number of the patient or the patient's sponsor.

(2) DATE OF TREATMENT. Date of the patient's treatment in the Emergency Room.

BOTH SUSPENSE LISTS

(3) REVIEW LEVEL. The number of the review that has not been completed.

(4) DATE OUT. The date when the review was sent out.

(5) DATE DUE. The date when the review was supposed to be received in QA.

(6) ACTION CODE. The code that indicates the person or committee to whom the review was sent. Table 6054.

DATA CHART - OCCURRENCE SCREENING SUSPENSE LIST
INPATIENT AND EMERGENCY SERVICE

OCCURRENCE SCREENING SUSPENSE LIST

REGISTER NUMBER	DISCHARGE DATE	REVIEW LEVEL	DATE OUT	DATE DUE	ACTION CODE
0006460	29 AUG 1985 Q2	1	29 AUG 1985	04 SEP 1985	A
0006470	23 JUL 1985 Q2	1	27 JUL 1985	10 AUG 1985	K

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

EMERGENCY SERVICE OCCURRENCE SCREENING SUSPENSE LIST

FMP	SSN	DATE OF TREATMENT	REVIEW LEVEL	DATE OUT	DATE DUE	ACTION CODE
20	394-34-8793	21 AUG 1985 Q3	1	21 AUG 1985	31 AUG 1985	A
20	394-34-8793	21 AUG 1985 Q6	1	21 AUG 1985	31 AUG 1985	A
20	879-87-9832	07 AUG 1985 Q6	1	07 AUG 1985	10 AUG 1985	K1
20	879-87-9832	07 AUG 1985 Q11	1	07 AUG 1985	11 AUG 1985	L1

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

PROVIDER OCCURRENCE SCREENING AUDIT, INPATIENT AND EMERGENCY SERVICE

a. Definition. These reports summarize affirmative checklist responses made about the patients of an individual health care provider, giving the text of each checklist item and the codes for actions taken regarding that item. The reports include records of patients for whom the provider specified is the primary provider, as it appears on the Inpatient or Emergency Service Occurrence Screening Checklist. The user specifies the provider, or can leaves this field blank and the report will sort and print data for all providers. The user also specifies the reporting period. Both reports are produced on demand, and their distribution is determined by the MTF command.

b. Format. Headers for both reports display the MTF name, the run date, the report title, the provider selected, and the reporting period. The report data is presented in table form, with one page of data on each patient, and up to three lines of data on each affirmative checklist response.

c. Content.

INPATIENT OCCURRENCE SCREENING AUDIT

(1) REG NO. Register number of the patient who had this health care provider and on whose record an affirmative response was found.

(2) DISCHARGE DATE. Disposition date of this patient.

EMERGENCY SERVICE OCCURRENCE SCREENING AUDIT

(1) FMP/SSN. Family member prefix of the patient on whose checklist the "yes" response appears (Table 1012). Social Security Number of the patient or the patient's sponsor.

(2) LOG NBR and DATE/TIME OF TREATMENT. Log number of the Emergency Room visit, and the date and time the patient was seen there for treatment.

BOTH OCCURRENCE SCREENING AUDITS

(3) NO. Number of the checklist item with an affirmative response. If more than one checklist item was answered "yes" on one patient's record, data on all those items will be included.

(4) OCCURRENCE DESCRIPTION. Text of the item, e.g., "Drug or transfusion reaction."

DATA CHART - PROVIDER OCCURRENCE SCREENING AUDIT,
INPATIENT AND EMERGENCY SERVICE

BOTH OCCURRENCE SCREENING AUDITS (continued)

(5) REVIEW LEVEL. The number of the last or current review performed regarding this "yes" response.

(6) DATE OUT. The date when this item was sent out for review.

(7) DATE DUE. The date when this result of this review is or was to be returned to QA.

(8) DATE IN. The date when the review result was received.

(9) ACTION CODE. Codes describing the actions taken regarding this checklist item.

1st code - indicates the job classification of the person or committee that the review was assigned to. Table 6054.
2nd code - indicates whether the case involved the patient's provider (1 = provider involved; 2 = not involved).
3rd code - indicates the result of the review. Table 6055.
4th code - indicates whether this variation is to be posted to the provider's profile (Y/N).

DATA CHART - PROVIDER OCCURRENCE SCREENING AUDIT,
INPATIENT AND EMERGENCY SERVICE

TEST NAVY MTF RUN DATE: 31 AUG 1985

PERSONAL DATA - PRIVACY ACT 1974

PROVIDER OCCURRENCE SCREENING AUDIT

PROVIDER ID: 110112112 PERIOD: 01 AUG 1985 THRU 31 AUG 1985

REG NO / NO / REVIEW	DISCHARGE DATE / OCCURRENCE DESCRIPTION / LEVEL	DATE OUT	DATE DUE	DATE IN	ACTION CODE
0000003	07 AUG 1985				
12	UNEXPECTED RETURN TO OPERATING ROOM				
1		25 AUG 1985	31 AUG 1985	29 AUG 1985	A1EY
0006464	21 AUG 1985				
7	ORGAN FAILURE (HEART, KIDNEY, LUNG, BRAIN) NOT PRESENT ON ADMISSION				
1		27 AUG 1985	29 AUG 1985	29 AUG 1985	D1L

TEST AFB RUN DATE: 07 JUN 1985

PERSONAL DATA - PRIVACY ACT 1974

PROVIDER EMERGENCY SERVICE OCCURRENCE SCREENING AUDIT

PROVIDER ID: 999999999 PERIOD: 08 MAY 1985 THRU 07 JUN 1985

FMP/SSN 20/854757321

NBR	OCCURRENCE DESCRIPTION				
REVIEW LEVEL		DATE OUT	DATE DUE	DATE IN	ACTION CODE
LOG NBR: 26	DATE/TIME OF TREATMENT: 22 MAY 1985				
3	PATIENT ARRIVES DOA OR DIES IN THE ER				
1		22 MAY 1985	27 MAY 1985	29 MAY 1985	A1DY
4	PATIENT LEAVES WITHOUT BEING SEEN OR LEAVES AGAINST MEDICAL ADVICE				
1		26 MAY 1985	29 MAY 1985		

QUALITY ASSURANCE PROBLEM AUDIT

a. Definition. This report presents data about QA problems, as recorded on the QA Problem Audit Screen. The user who requests this report specifies whether the report is to include resolved or unresolved problems or both. The QA Problem Audit is printed on request, and its distribution is determined by the MTF command.

b. Format. The report header displays the MTF name, the run date, the Privacy Act Statement, the report title, and the type of problems included (Y = resolved, N = unresolved). The body of the report lists problems in order of the problem number, and contains the data described in the Data Chart below.

c. Content. Problems are listed in order of the problem number. The report contains the information described below for each problem.

(1) NUMBER. Number assigned to the record of the problem.

(2) DATE PRESENTED. Date when the problem was presented.

(3) REFERRAL ACTIVITY. The person or area of the MTF reporting the problem (e.g., a nurses' station).

(4) IMPACT ON PATIENT CARE.

(5) ACTION ACTIVITY. The person or group who took the action.

(6) STATUS DATE. The effective date of the information on this action.

(7) FOLLOWUP DATE. The date when any followup activity occurred regarding this action.

(8) ACTION TAKEN. The nature of the action taken.

DATA CHART - QUALITY ASSURANCE PROBLEM AUDIT

TRAINING HOSPITAL RUN DATE: 08 JUL 1985

PERSONAL DATA - PRIVACY ACT 1974

* * * * * QUALITY ASSURANCE PROBLEM AUDIT * * * * *

RESOLVED TYPE: N

ACTION ACTIVITY STATUS DATE FOLLOW UP DATE
ACTION TAKEN

NUMBER 4 DATE PRESENTED: 10 JAN 1985 REFERRAL ACTIVITY: COMPTROLLER
IMPACT ON PATIENT CARE:
BUDGET INCREASE FOR PHARMACY EXPENDITURES;CAN APPROPRIATE MEDS BE
FOUND FOR PATIENT CARE & STILL MEET BUDGET CONSTRAINTS

PHARM&THER 19 JAN 1985 29 MAR 1985
COMMITTEE REVIEW FOR MORE GENERIC USE &/OR DELETION OF HIGH COST

NUMBER 25 DATE PRESENTED: 23 APR 1985 REFERRAL ACTIVITY: NSG QA COMM
IMPACT ON PATIENT CARE:
RECENT PRACTICE OF ADMISSION ORIENTATION DOES NOT PROVIDE PATIENTS WITH
INFO. ON USE OF MECHANICAL BEDS

NSG PROC COMM 26 APR 1985 01 MAY 1985
DISCUSSED AT LAST MEETING, PLAN TO ADD

NUMBER 29 DATE PRESENTED: 09 MAY 1985 REFERRAL ACTIVITY: 3S NURSE ST
IMPACT ON PATIENT CARE:
DANGER TO AMBULATORY PTS USING 3S PUBLIC RESTROOM

LEAKY CEILING 12 MAY 1985 14 MAY 1985
REPORTED TO MAINTENANCE COMM

NUMBER 30 DATE PRESENTED: 09 APR 1985 REFERRAL ACTIVITY: 4E NURS STA
IMPACT ON PATIENT CARE:
INADEQUATE AIR CONDITIONING

FELL OUT OF BED 20 MAY 1985 25 MAY 1985
OUT RAILS ON SIDE OF BED

VENT MALFUNCTIO 21 MAY 1985 09 SEP 1999
REPORTED TO MAINTENANCE

REPORTED AGAIN 30 MAY 1985 04 JUN 1985
MAINTENANCE TRIED TO REPAIR AGAIN

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

SURGICAL INDEX BY PROVIDER

a. Definition. This report gives information about surgical procedures performed during the reporting period. To be included on the report, a patient record must have a disposition date falling within the reporting range, and must have a Clinical Records status of A or T. The user can specify the provider for the report, or leave the field blank and the report will include data on all providers (in that case, data on each provider will begin on a new page). The Surgical Index is printed on request.

b. Format. The header for this report includes the report name, the provider name, and the MTF name. The date on the right is the end date for the reporting period. The body of the report is in table form, and contains the data described below.

c. Content.

The first line, ALL SURGICAL CASES, gives totals for the provider specified (e.g., the total number of operations performed by this provider).

(1) ICDA CODE. The ICP code for the procedure. Table 9002.

(2) OPERATION TITLE. Name of the operation. Table 9002.

(3) OPERATIONS: TOTAL. The number of times the specified provider performed the indicated procedure during the reporting period.

(4) PRIMARY. The number of times the specified provider was the primary provider for the indicated operation.

(5) ASSISTS. The number of times the specified provider was the assistant during the indicated operation.

(6) DEATHS. The number of deaths associated with the performance of the indicated procedure during the reporting period.

DATA CHART - SURGICAL INDEX BY PROVIDER

PREPARED 04 SEP 1985 INDIVIDUAL MEDICAL RECORDS INPATIENT REPORTING AS OF 85 SEP 04
QUARTERLY SURGICAL INDEX BY PROVIDER OF CARE PART 9
STAFF DOCTOR
TEST NAVY MTF

ICDA CODE	OPERATION TITLE	****** OPERATIONS ***** TOTAL	PRIMARY	ASSISTS	DEATHS
	ALL SURGICAL CASES	2	2		
1270	JUGULAR VEIN CATHETERIZATION	1	1		
5011	CRANIOTOMY	1	1		

SURGICAL INDEX BY PROVIDER

SURGICAL OPERATIONS REPORT

a. Definition. This report gives information on all surgical procedures performed in the MTF during the reporting period specified by the user. To be included on the report, a record must have a disposition date that falls within the reporting period, and must have a Clinical Records status of A or T. This report is printed on request.

b. Format. The header for this report includes the report name and MTF name. The date on the right is the ending date for the reporting period. The body of the report is in table form and contains the data described below.

c. Content.

(1) SURGICAL OPERATIONS. The CODE field shows the ICP code of the procedure, and the TITLE field shows its descriptive title. Table 9002.

(2) PRIN OP. The number of times the indicated procedure was the principle procedure for the patient.

(3) PERSONNEL CATEGORY. These fields show the personnel category of the patient for whom the indicated procedure was the principle procedure performed. NAVY AD = Navy active duty; OTH AD = other active duty; MIL DPN = military dependent; MIL RET = military retired; ALL OTH = others.

(4) AGE. These fields show the age ranges of the patients for whom the indicated procedure was the principle procedure performed. UNDR 28D = under 28 days; 1M - 13Y = 1 month to 13 years old; 14Y - 64Y = 14 years to 64 years; etc.

(5) ASSOC OP. The number of times the indicated procedure was the associated operation for the patient.

DATA CHART - SURGICAL OPERATIONS REPORT

PREPARED 04 SEP 1985 QUARTERLY

INDIVIDUAL MEDICAL RECORDS INPATIENT REPORTING AS OF 85 SEP 04
SURGERY PERFORMED IN THIS HOSPITAL PART 4
TEST NAVY MTF

** SURGICAL OPERATION CODE	** TITLE	PRIN OP	PRINCIPLE OPERATION *PERSONNEL CATEGORY* NAVY AD	OTH AD	MIL DPN	MIL RET	ALL OTH	******** AGE ******** UNDR 28D	1M- 13Y	14Y- 64Y	OVER 65	ASSOC OP
1270	JUGULAR VEIN CATHET	1	1							1		
1274	TRANSSEPTAL CARDIAC	1			1				1			
5011	CRANIOTOMY											1

SURGICAL OPERATIONS REPORT

CREDENTIAL PULL LIST

a. Definition. This report lists health care providers whose credential renewal dates fall within the time period of the report, which is specified by the requestor. The report is used to facilitate pulling the records of providers whose credentials will be up for review. It is produced on request, and is distributed to the professional services.

b. Format. The header for this report displays the name of the MTF, the run date, the report title, and the reporting period. The body of the report is in table form, and includes the data described below.

c. Content.

(1) PROVIDER NAME. Name of the health care provider.

(2) SPECIALTY. Code for the provider's clinical specialty. Table 2005.

(3) ACLS. Date when the provider was certified in Advanced Cardiac Life Support.

(4) CREDENTIAL RENEWAL. Date when the provider's credentials with this MTF are due for renewal by the Credentials Committee. Information on this provider will only appear on this report if the credential renewal date falls within the reporting period.

(5) LICENSE RENEWAL. Date when the provider's license is due to be renewed by the state licensing board.

(6) CPR TRAINING. Date when the provider completed training in cardiopulmonary resuscitation (CPR).

DATA CHART - CREDENTIAL PULL LIST

TEST AFB

RUN DATE: 07 JUN 1985

CREDENTIAL PULL LIST
PERIOD: 07 JUN 1985 THRU 07 JUL 1985

PROVIDER NAME / SPECIALTY	ACLS	CREDENTIAL RENEWAL	LICENSE RENEWAL	CPR TRAINING
FIELDING,JOHN M M.D. F.A.C.				
AAG	21 JUL 1984	16 JUN 1985	16 JUN 1985	17 APR 1985
KUTT,I				
ABA	02 FEB 1985	04 JUL 1985		04 MAR 1985
SPEARS,DOC				
AAB	15 MAY 1984	15 JUN 1985	01 JUL 1985	24 MAY 1985
STAFF				
AAP		07 JUN 1985		24 MAY 1985
TINKER,DOC				
AAG	17 MAR 1985	15 JUN 1985	14 JUN 1985	15 MAY 1985

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

PROVIDER PROCEDURE/MORTALITY SUMMARY

a. Definition. This report gives the mortality rate for procedures that fall within any of the 26 categories of procedures that are reportable to DoD. One page of data is presented for each provider who acted as the primary, secondary, or teaching assistant during a procedure that was associated with the patient's death. This report only includes records that have been approved in Clinical Records. It is produced on request and is submitted to DoD.

b. Format. The header of the report displays the name of the MTF, the run date, the Privacy Act Statement, and the report title. The top of each page displays the QA ID of the provider. The body of the report is in table form and contains two lines of data on each procedure.

c. Content.

(1) PROCEDURE TEXT. The number of the DoD-reportable category to which this procedure belongs, and the description of the procedure. Table 6056.

(2) PROCS PERFORMED. The number of times this procedure was performed by this provider, whether associated with patient death or not.

(3) DEATHS. The number of deaths associated with the performance of this procedure by this provider (whether as the primary or secondary provider, or as a teaching assistant).

(4) MORT RATE. The mortality rate for this provider for this procedure, determined from items (2) and (3).

(5) RATE CRITERION. The normal percentage of deaths associated with this procedure in the population at large. Table 6056.

(6) ANES RISK CODE CNTS. The anesthetic risk code is a number from 1 to 5 that indicates the risk posed for a given patient in undergoing a given procedure. The anesthetic risk codes of the patients who died as a result of this procedure (item 3 above) are shown in the fields labeled 1, 2, 3, 4, 5, and UNK. For example, 4 people died after undergoing a specified procedure performed by a specified provider. If 2 of them had risk codes of 3, 1 patient had a risk code of 4, and 1 had an unknown risk code, these fields would appear as follows:

1	2	3	4	5	UNK
0	0	2	1	0	1

DATA CHART - PROVIDER PROCEDURE/MORTALITY SUMMARY

PERSONAL DATA - PRIVACY ACT 1974

PROVIDER PROCEDURE/MORTALITY SUMMARY
PROVIDER ID: 657576575

PROCEDURE TEXT PROCS PERFORMED	DEATHS	MORT RATE	RATE CRITERION	ANES RISK CODE CNTS 1 2 3 4 5 UNK
25 BYPASS ANASTAMOSIS, HEART 1	1	100	10	0 0 0 0 0 1

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER.

PROVIDER PROCEDURE SUMMARY

a. Definition. This report gives mortality information for all procedures associated with a patient death, not just procedures that fall into the 26 categories reportable on the Procedure/Mortality Summary. One page of data is displayed for each provider who acted as primary or secondary provider or as teaching assistant during the procedure. The report only includes records that have been approved in Clinical Records. It is produced on request, and its distribution is determined by the MTF command.

b. Format. This report displays the same header information as the Procedure/Mortality Summary: MTF name, run date, Privacy Act Statement, and report title. The top of each page displays the ID of the provider. The body of the report is in table form and contains two lines of data on each procedure.

c. Content.

(1) PROCEDURE CODE. The ICP code of the procedure. Table 9002.

(2) TEXT. The description of the procedure. Table 9002.

(3) PROCS PERFORMED. The number of times this procedure was performed by this provider, whether associated with patient death or not.

(4) DEATHS. The number of deaths associated with the performance of this procedure by this provider (whether as the primary or secondary provider, or as a teaching assistant).

(5) MORTALITY RATE. The mortality rate for this provider for this procedure, determined from items (3) and (4).

(6) ANES RISK CODE CNTS. The anesthetic risk code is a number from 1 to 5 that indicates the risk posed for a given patient in undergoing a given procedure. The anesthetic risk codes of the patients who died as a result of this procedure (item 4 above) are shown in the fields labeled 1, 2, 3, 4, 5, and UNK. For example, 4 people died after undergoing a specified procedure performed by a specified provider. If 2 of them had risk codes of 3, 1 patient had a risk code of 4, and 1 had an unknown risk code, these fields would appear as follows:

1	2	3	4	5	UNK
0	0	2	1	0	1

DATA CHART - PROVIDER PROCEDURE SUMMARY

PERSONAL DATA - PRIVACY ACT 1974

PROVIDER PROCEDURE SUMMARY
PROVIDER ID: 910109109

PROCEDURE: CODE / PROCS PERFORMED	TEXT / DEATHS	MORTALITY RATE	ANES RISK CODE CNTS 1	2	3	4	5	UNK
592	CLOSED HEART VALVOTOMY							
2	1	50	0	0	0	0	0	1

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PROVIDER PROFILE

a. Definition. The Provider Profile gives information about an individual provider, including dates for credential and license renewal, and dates when the provider was trained in CPR, and certified in ACLS and ATLS. It also shows data, accumulated for six-month periods, on number of procedures performed and patients discharged, malpractice claims, medical records deficiencies and delinquencies, and validated variations discovered for this provider through the Occurrence Screening process. The user specifies the provider for the report when requesting it. The Provider Profile is produced on request, and its distribution is determined by the MTF command.

b. Format. The header of this report displays the MTF name, the run date, the Privacy Act Statement, and the report title. The body of the report contains data on the provider. The Clinical Indicator Totals section is in the form of a table, with the type of clinical indicators listed across the top, and the beginning date of the six-month periods listed in the left-hand column, as described below.

c. Content.

(1) NAME. Full name of the provider specified by user requesting this report.

(2) SPECIALTY. Clinical specialty of the provider. Table 2005.

(3) ID CODE. ID code of the provider.

(4) CONT ED (YY/HH). The continuing education credit hours completed by this provider for the last three years. The current year appears first, then the previous year, then the year before that. The HH field displays the number of credit hours earned in the year indicated.

(5) ASGN DATE. Date on which the provider was assigned to this MTF.

(6) DATE OF: CPR TRAINING. Date when the provider completed training in cardiopulmonary resuscitation.

(7) ACLS CERT. Date when the provider was certified in Advanced Cardiac Life Support.

DATA CHART - PROVIDER PROFILE

(8) ATLS CERT. Date when the provider was certified in Advanced Trauma Life Support.

(9) CREDENTIAL RENEWAL. Date when the provider's credentials to practice at this MTF are to be renewed by the Credentials Committee.

(10) LICENSE: RENEWAL. Date when the provider's license is to be renewed by the state licensing board.

(11) STATE. State in which the provider is licensed.

CLINICAL INDICATOR TOTALS

(12) PERIOD BEGINNING. This column shows the beginning date of the 6-month period for which the clinical indicator data was accumulated. These dates are displayed in order from most recent to least recent.

(13) PROC PERF. Number of procedures for which this provider acted as primary or secondary provider or teaching assistant during the indicated 6-month period.

(14) PAT DISC. Number of patients whose dispositions were ordered by this provider during the 6-month period.

(15) MAL CLAIM. Number of malpractice claims filed against this provider during the 6-month period.

(16) MED DEF. Number of medical records considered deficient because this provider did not supply parts of the chart (e.g., history/physical) by the time the record was accessed in Clinical Records.

(17) RECD DELQ. Number of medical records considered delinquent because this provider had not supplied parts of the chart within the time limit set by the MTF.

(18) ANTI VARI. The number of times that the QA audit and review process determined that occurrence screening variations related to antibiotic use should be posted to this provider's profile.

(19) COMPL. The number of validated patient complaints lodged against this provider.

DATA CHART - PROVIDER PROFILE

(20) NORM TISS. The number of times that the QA audit and review process determined that occurrence screening variations related to normal surgical tissue should be posted to this provider's profile.

(21) TRANS. The number of times that the QA audit and review process determined that occurrence screening variations related to transfusions should be posted to this provider's profile.

(22) SCRN VARI. The number of times that the QA audit and review process determined that occurrence screening variations should be posted to this provider's profile.

(23) TOTAL DEATH. The number of patient deaths that the audit process has indicated should be posted to this provider profile.

DATA CHART - PROVIDER PROFILE

TEST AFB RUN DATE: 11 JUL 1985

PERSONAL DATA - PRIVACY ACT OF 1974
PROVIDER PROFILE

NAME: ADDISON,THOMAS J SPECIALTY: NEUROLOGY
ID CODE: 910109109 CONT ED (YY/HH) 85/0 84/0 83/0 ASGN DATE: 01 MAY 1972

DATE OF: CPR TRAINING ACLS CERT ATLS CERT
CREDENTIAL RENEWAL LICENSE: RENEWAL STATE

--- CLINICAL INDICATOR TOTALS ---

PERIOD BEGINNING	PROC PERF	PAT DISC	MAL CLAIM	--MED REC DEF	D- DELQ	ANES VART	COMPL	NORM TISS	TRANS	SCRN VART	TOTAL DEATH
01 JAN 1985	1	0	0	0	0	0	0	0	0	0	0
01 JUL 1984	0	0	0	0	0	0	0	0	0	0	0
01 JAN 1984	0	0	0	0	0	0	0	0	0	0	0
01 JUL 1983	0	0	0	0	0	0	0	0	0	0	0
01 JAN 1983	0	0	0	0	0	0	0	0	0	0	0
01 JUL 1982	0	0	0	0	0	0	0	0	0	0	0
01 JAN 1982	0	0	0	0	0	0	0	0	0	0	0

A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER

PROVIDERS WITH INSUFFICIENT CONTINUING EDUCATION REPORT

a. Definition. The Continuing Education report lists providers who have fewer credit hours of continuing education than the number entered by the user requesting the report. This report is printed on demand.

b. Format. The header of this report contains the MTF name, the run date, and the report title, giving the number of credit hours specified.

c. Content. The body of the report is in table form, giving the name of the provider who has fewer credit hours than the number specified, the number of the provider's credit hours, and the date on which the provider was assigned to this MTF.

TEST NAVY MTF RUN DATE: 31 AUG 1985

PROVIDERS WITH INSUFFICIENT CONTINUING EDUCATION
LESS THAN 6 CE HOURS

PROVIDER	YR HOURS	MTF ASSIGNMENT DATE
DILLON, JOHN	85 2	01 OCT 1982
FREDERICKS,WALTER	85 3	08 JUN 1985
HENRY,O.	85 0	10 OCT 1984
JOHNS, MIKE	85 0	02 JAN 1985
NEWMAN,PAUL	85 0	25 APR 1985
RILEY, JAMES	85 0	12 APR 1984
ROGERS,STEVEN J, OB/G	85 0	06 MAY 1983
STAFF DOCTOR	85 1	03 JUN 1984
THOMAS, TOM	85 0	10 OCT 1981
WHITE, JAMES	85 0	01 MAR 1983

PROVIDERS WITH INSUFFICIENT CONTINUING EDUCATION REPORT

UH007

Appendix E

BUSINESS OFFICE INPUTS AND OUTPUTS

To be submitted at a later date.

Appendix F

SYSTEM TABLES

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*Listings on some of the following tables are intended to be specified by the individual MTF. Each of these MTF-specific tables is marked as a "Sample" on this Table of Contents. The "Samples" are included in this appendix to show the kind of data these tables can contain, not the only correct data that can be entered in AQCESS.

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RELIGION (table) AUG 31,1985 19:39 PAGE 1

RELIGION CODE	DESCRIPTION	SVC FLAG
ABC	AMERICAN BAPTIST CHURCH	AFN
AGC	ASSOCIATED GOSPEL CHURCHES	AFN
AGN	AGNOSTIC	AFN
AOG	ASSEMBLY OF GOD	AFN
ATH	ATHEIST	AFN
BAP	BAPTIST CHURCHES, OTHER	AFN
BCD	BRETHREN CHURCH - DUNKERS	AFN
BIC	BRETHREN IN CHRIST	AFN
BUD	BUDDHISM	AFN
CAT	ROMAN CATHOLIC	AFN
CND	CHRISTIAN NON-DENOMINATIONAL	AFN
COC	CHURCH OF CHRIST	AFN
COG	CHURCH OF GOD	AFN
CSC	CHRISTIAN SCIENCE	AFN
DOC	DISCIPLES OF CHRIST	AFN
EPI	EPISCOPAL CHURCH	AFN
EVC	EVANGELICAL CHURCH	AFN
FRN	FRIENDS - QUAKERS	AFN
FWB	FREEWILL BAPTIST CHURCH	AFN
GGC	GRACE GOSPEL CHURCH	AFN
HIN	HINDU	AFN
JEW	JEWISH	AFN
JWI	JEHOVAH WITNESS	AFN
LDS	JESUS CHRIST OF LDS (MORMONS)	AFN
LMS	LUTHERN, MISSOURI SYNOD	AFN
LUT	LUTHERAN	AFN
MET	METHODIST	AFN
MUS	MUSLIM	AFN
NAZ	NAZARENE	AFN
NRP	NO PREFERENCE	AFN
ORT	ORTHODOX	AFN
OTH	OTHER	AFN
PBT	PRESBYTERIAN	AFN
PEN	PENTOCOSTAL	AFN
PND	PROTESTANT NON-DENOMINATIONAL	AFN
POC	PROTESTANT OTHER CHURCHES	AFN
REF	REFORMED CHURCH	AFN
SBP	SOUTHERN BAPTIST	AFN
SDA	SEVENTH DAY ADVENTIST	AFN
SVC	SALVATION ARMY	AFN
UMO	UNITED METHODIST	AFN
UNI	UNITED CHURCH	AFN
UNK	UNKNOWN	AFN
UNU	UNITARIAN UNIVERSALIST	AFN

PATIENT CATEGORY (AIR FORCE)

AUG 31,1985 19:39 PAGE 1

PATIENT CATEGORY	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY
A11	ACT-DUTY ARMY	110001			
A12	ARMY NAT GUARD	110001			
A13	CADET ARMY ACADEMY	110001			
A14	FEMALE FORMER MILITARY ARMY	91000100			
A21	ARMY RESERVE	110001			
A31	RET (LOS) ARMY	210001			
A32	RET (PDRL) ARMY	210001			
A33	RET (TDRL) ARMY	210001			
A41	DEPN AD ARMY	301000			
A42	DEPN RET ARMY	301000			
A43	DEP AD/DEC ARMY	301000			
A44	DEP RET/DEC ARMY	301000			
A45	NEWBORN OF FEMALE FORMER ARMY	31000000			
A51	AD NATO ARMY	91000			
A52	DEPN NATO ARMY	901000			
F11	ACT-DUTY USAF	110011			
F12	AF NAT GUARD	110001			
F13	CADET USAF ACAD	110001			
F14	FEMALE FORMER MILITARY USAF	91000100			
F21	AF RESERVE	11001			
F31	RET (LOS) USAF	210001			
F32	RET (PDRL) USAF	210001			
F33	RET (TDRL) USAF	210001			
F41	DEPN AD USAF	301000			
F42	DEPN RET USAF	301000			
F43	DEPN AD/DEC USAF	301000			
F44	DEPN RET/DEC USAF	301000			
F45	NEWBORN OF FEMALE FORMER USAF	31000000			
F51	AD NATO AF	910000			
F52	DEPN NATO AF	901000			
M11	ACT-DUTY MARINE	110001			
M12	USMC NAT GUARD	110001			
M14	FEMALE FORMER MILITARY USMC	91000100			
M21	USMC RESERVE	110001			
M31	RET (LOS) USMC	210001			
M32	RET (PDRL) USMC	210001			
M33	RET (TDRL) USMC	210001			
M41	DEPN AD USMC	301000			
M42	DEPN RET USMC	301000			
M43	DEPN AD/DEC USMC	301000			
M44	DEPN RET/DEC USMC	301000			
M45	NEWBORN OF FEMALE FORMER USMC	31000000			
M51	AD NATO MARINE	910000			
M52	DEPN NATO MARINE	901000			
N11	ACT-DUTY NAVY	110001			
N12	NAVY NAT GUARD	110001			
N13	MIDSHIPMAN NAVY	110001			
N14	FEMALE FORMER MILITARY NAVY	91000100			
N21	NAVY RESERVE	110001			
N31	RET (LOS) NAVY	210001			
N32	RET (PDRL) NAVY	210001			
N33	RET (TDRL) NAVY	210001			
N41	DEPN AD NAVY	301000			
N42	DEPN RET NAVY	301000			
N43	DEPN AD/DEC NAVY	301000			
N44	DEPN RET/DEC NAVY	301000			

PATIENT CATEGORY	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY
N45	NEWBORN OF FEMALE FORMER NAVY	31000000			
N51	AD NATO NAVY	910000			
N52	DEPN NATO NAVY	90,000			
011	ACT-DUTY NOAA	11000100			
012	NOAA NAT GUARD	11000100			
021	NOAA RESERVE	11000100			
031	RET (LOS) NOAA	21000100			
032	RET (PDRL) NOAA	21000100			
033	RET (TDRL) NOAA	21000100			
041	DEPN AD NOAA	30100000			
042	DEPN RET NOAA	30100000			
043	DEPN AD/DEC NOAA	30100000			
044	DEPN RET/DEC NOAA	30100000			
P11	ACT-DUTY USCG	11000100			
P12	CG NAT GUARD	11000100			
P13	CADET USCG ACADEMY	11000100			
P21	USCG RESERVE	11000100			
P31	RET (LOS) USCG	21000100			
P32	RET (PDRL) USCG	21000100			
P33	RET (TDRL) USCG	21000100			
P41	DEPN AD USCG	30100000			
P42	DEPN RET USCG	30100000			
P43	DEPN AD/DEC USCG	30100000			
P44	DEPN RET/DEC USCG	30100000			
W11	ACT-DUTY USPHS	11000100			
W12	USPHS NAT GUARD	11000100			
W21	USPHS RESERVE	11000100			
W31	RET (LOS) USPHS	21000100			
W32	RET (PDRL) USPHS	21000100			
W33	RET (TDRL) USPHS	21000100			
W41	DEPN AD USPHS	30100000			
W42	DEPN RET USPHS	30100000			
W43	DEPN AD/DEC USPHS	30100000			
W44	DEPN RET/DEC USPHS	30100000			
X19	FORMER POW/HOSTAGE	91000000			
X53	ACT-DUTY NON-NATO	91000000			
X54	DEPN AD NON-NATO	90100000			
X55	CIV IN SATP	91000000			
X56	DEPN CIV IN SATP	90100000			
X57	FOREIGN NATL IN US	91000000			
X58	FOREIGN NATL - US EMPL	91000000			
X59	FOREIGN NATL - OTHER BENE	91000000			
X61	CIV EMPL OVERSEA	91010000			
X62	DEPN CIV EMPL OVERSEA	90110000			
X63	STATE DEPT EMPL OVERSEA	91010000			
X64	DEPN STATE DEPT EMPL OVERSEA	90110000			
X65	CIV EMPL EXECUTIVE	91010000			
X69	OTHER CIV EMPL	91010000			
X71	CIV VA BENE	910100			
X72	CIV WORKMAN COMP PROGRAM	91010000			
X73	CIV SOC SEC ADMIN	91010000			
X74	CIV SPECIAL BENE	91010000			
X75	AMERICAN INDIAN	91010000			
X76	FED PRISONER	91010000			
X81	RED CROSS	91010000			
X82	ENLST/APPLC TO ACAD	91010000			

PATIENT CATEGORY (AIR FORCE)

PATIENT CATEGORY	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY
X83	POW	91010000			
X84	INTERNEES	91010000			
X91	CIV ER	91010000			
X98	OTHER CIV	91010000			
X99	OTHERS	91010000			

PATIENT CATEGORY (ARMY) AUG 31,1985 19:11 PAGE 1

PATIENT CATEGORY	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY
A11	USA AD OFFICER	1100011	ARMY	4-1	SB
A12	USA AD ENLISTED	110001	ARMY	4-1	SB
A21	USAR INIT ACDUTRA RESERVE	110011	IADT	4-2	SB
A22	USAR RES (<31 DAYS) ENLISTED	110001	USART	4-2	NC
A23	USAR RES (<31 DAYS) OFFICER	1100011	USART	4-2	SB
A24	USAR INITL ACDUTRA (REP 63) ARNGUS	110001	IADT	4-2	SB
A25	USA NG (<31) ENLISTED	110001	ARNGU	4-2	SB
A26	USA NG (<31) OFFICER	1100011	ARNGU	4-2	SB
A27	USA NG ENL PROG ACDUTRA	110001	ARNGU	4-2	SB
A28	USAR RES ENL PROG ACDUTRA	110001	USAR	4-2	SB
A29	USAR NON-AD/ACDUTRA, RES/ARNG OFF	910001	ARNGU	4-2	SB
A31	USA RET LOS OFFICER	2100011	RET/A	4-11	SB
A32	USA RET LOS ENLISTED	210001	RET/A	4-11	NC
A33	USA PDRL OFFICER	2100011	PDRL/	4-11	SB
A34	USA PDRL ENLISTED	210001	PDRL/	4-11	NC
A41	USA TDRL OFFICER	2100011	TDRL/	4-11	SB
A42	USA TDRL ENLISTED	210001	TDRL/	4-11	NC
A51	DEPN AD US ARMY SPONSOR	301000	DEP/A	4-12	B
A52	PREADOPT CHILD AD USA SPONSOR	301000	PREAD	4-56	B
A61	DEPN RET USA SPONSOR	301000	DEP/R	4-12	B
A62	DEPN DECEASED USA SPONSOR	301000	DEP/D	4-12	B
A63	PREADOPT CHILD RET USA SPONSOR	301000	PREAD	4-56	B
A71	US MILITARY ACAD CADETS	110001	USMA	4-1	SB
A81	USA ROTC CADETS (OWN PAY)	910001	ROTC	4-4	A3
A82	US ARMY ROTC CADET APPLICANTS	910001	ROTC	4-5	SB
A91	SEC OF ARMY DESIGNEE (NO PAY)	910000	DOD D	4-55	NC
A92	ARMY SEC DES (SB PAY)/RECORDS	910000	DOD D	4-55	SB
A93	ARMY SEC DES (FULL PAY) /EVAC	910000	DOD D	4-55	A3
A94	ARMY SEC DES (DEPN RATE)	201000	DOD D	4-55	B
A95	ARMY SEC DES (ISR RATE)	910000	DOD D	4-55	A3
C11	USCG ACTIVE DUTY OFFICER	110001	USCG	4-1	X
C12	USCG ACTIVE DUTY ENLISTED	110001	USCG	4-1	X
C22	USCG RES (<31 DAYS) ENLISTED	110001	USCGT	4-2	X
C23	USCG RES (<31 DAYS) OFFICER	110001	USCGT	4-2	X
C28	USCG NON-AD/ACDUTRA RES ENLISTED	910001	USCGI	4-2	X
C29	USCG NON-AD/ACDUTRA RES OFFICER	910001	USCGI	4-2	X
C31	USCG RET LOS OFFICER	210001	RET/U	4-11	X
C32	USCG RET LOS ENLISTED	210001	RET/U	4-11	DDA1
C33	USCG PDRL OFFICER	210001	PDRL/	4-11	X
C34	USCG PDRL ENLISTED	210001	PDRL/	4-11	DDA1
C41	USCG TDRL OFFICER	210001	TDRL/	4-11	X
C42	USCG TDRL ENLISTED	210001	TDRL/	4-11	DDA1
C51	DEPN USCG AD SPONSOR	301000	DEP/A	4-12	Y
C52	PREADOPT CHILD USCG AD SPONSOR	301000	PREAD	4-56	Y
C61	DEPN USCG RET SPONSOR	301000	DEP/R	4-12	Y
C62	DEPN USCG DECEASED SPONSOR	301000	DEP/D	4-12	Y
C63	PREADOPT CHILD USCG RET SPONSOR	301000	PREAD	4-56	Y
C71	USCG ACADEMY CADETS	110001	CAD/U	4-1	Y
F11	USAF AD OFFICER	110001	USAF	4-1	SB
F12	USAF AD ENLISTED	110001	USAF	4-1	SB
F21	USAF INITL ACDUTRA (REP 63) RES	110001	USAFT	4-2	SB
F22	USAF RES (<31 DAYS) ENLISTED	110001	USAFT	4-2	SB
F23	USAF RES (<31 DAYS) OFFICER	110001	USAFT	4-2	SB
F24	USAF INITL ACDUTRA (REP 63) AFNG	110001	USAFT	4-2	SB
F25	USAF NG (<31 DAYS) ENLISTED	110001	AFNGT	4-2	SB
F26	USAF NG (<31 DAYS) OFFICER	110001	AFNGT	4-2	SB

PATIENT CATEGORY	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY
F27	USAF NON-AD/ACDUTRA AFNG ENL	910001	AFNGI	4-2	SB
F28	USAF NON-AD/ACDUTRA RES ENL	910001	AFNGI	4-2	SB
F29	USAF NON-AD/ACDUTRA RES OFF	910001	AFNGI	4-2	SB
F31	USAF RET LOS OFFICER	210001	RET/A	4-11	SB
F32	USAF RET LOS ENLISTED	210001	RET/A	4-11	NC
F33	USAF PDRL OFFICER	210001	PDRL/	4-11	SB
F34	USAF PDRL ENLISTED	210001	PDRL/	4-11	NC
F41	USAF TDRL OFFICER	210001	TDRL/	4-11	SB
F42	USAF TDRL ENLISTED	210001	TDRL/	4-11	NC
F51	DEPN USAF AD SPONSOR	301000	DEP/A	4-12	B
F52	PREADOPT CHILD USAF AD SPON	301000	PREAD	4-56	B
F61	DEPN USAF RET SPONSOR	301000	DEP/R	4-12	B
F62	DEPN USAF DECEASED SPONSOR	301000	DEP/D	4-12	B
F63	PREADOPT CHILD USAF RET SPON	301000	PREAD	4-56	B
F71	USAF ACADEMY CADETS	110001	USAFA	4-1	SFSB
F81	USAF ACAD ROTC CADETS (PAY)	110001	ROTC	4-4	A3
F82	USAF ACAD ROTC CADET APPLIC	110001	ROTC	4-5	SFSB
H11	STATE DEPT EMPLOYEES	910000	ST DE	4-32	DDA1
H12	AID EMPLOYEES	910000	AID E	4-32	SFA1
H13	COMMERCE DEPT EMPLOYEES	910000	COM D	4-27	SFA1
H14	DRUG ENF ADMIN EMPLOYEES	910000	DEA E	4-32	SFA1
H15	FAA EMPLOY/AIR TRF EMPLOYS	910000	FAA E	4-32	SFA1
H16	FRGN CLAIMS SETTLMNT COMM EMPLOYS	91000	COMM	4-32	SFA1
H17	USIA EMPLOYEES	910000	USIA	4-32	SFA1
H18	AGRICULTURAL DEPT EMPLOYEES	910000	USDA	4-32	SFA1
H19	FGN NATL STATE DPT/AID EMPLOYS	910000	FN ST	4-32	SFA1
H21	INT DEPT EMPLOYEES (SAMOA)	910000	INT D	4-22	A1
H22	TRANS DEPT EMPLOYEES	910000	TRAN	4-27	A1
H23	JUSTICE DEPT EMPLOYEES	910000	JUST	4-35	DDA1
H24	TREAS DEPT EMPLYS (SEC SVC)	910000	TRES	4-36	A1
H25	HEW DEPT EMPLOYEES	910000	HEW E	4-27	A1
H26	CIV EMPL DOD AUTH OCC HEALTH	910000	DOD E	4-20	SB
H31	SECURITY EXC COMM EMPLOYEES	910000	SEC E	4-27	A1
H32	LIBR OF CONGREE EMPLOYEES	910000	LIB O	4-27	A1
H33	ENVIROMENTAL PROT AGENCY EMP	910000	EPA E	4-27	A1
H34	SOC SECY ADMIN EMPLOYEES	910000	SSA E	4-27	A1
H35	GSA EMPLOYEES	910000	GSA E	4-27	A1
H36	US CIV FED EMPLOYEES CONUS	910000	CIV F	4-27	A1
H37	US CIV FED EMPL AUTH OCC HLTH SVC	910000	CIV F	4-20	A1
H38	CIV EMPL US GOVT DIS RET EXAM	910000	CIV E	4-19	SB
H39	US CUSTOMS SERVICE AGENT	910000	CUST	4-36	DDA1
H41	CIV FACULTY U OF HLTH SCIENCES	910000	FAC U	4-68	A3
H42	SECRET SERVICE PROTECTEES	910000	PROT	4-42	SB
H43	CIV EMPL ARMY NATL GUARD	910000	ARNGU	4-61	SB
H44	SEC SVC SPECIAL AGENTS	910000	SPEC	4-36	X
H45	FGN NATL EMPL US CONGRESS OCONUS	910000	US CO	4-25	A3
H46	CIV EMPL DOD ALCH TRTMNT PROG	910000	DOD E	4-19	NC
H51	FED CIV EMPLOYEE IN REMOTE AREAS	910000	US GO	4-19	SFA3
J11	DEPN STATE DEPT EMPLOYEE	901000	DEP S	4-32	SFA1
J12	DEPN US CITY AID EMPL (FULL PAY)	901000	DEP A	4-32	SFA3
J13	COMM DEPT EMP (BUR OF PUB RDS)	901000	DEP C	4-27	SFA1
J14	DEPN FAA EMPL	901000	DEP F	4-32	SFA1
J15	DEPN FGN CLAIMS SETTLMNT COMM EMPL	901000	DEP C	4-32	SFA1
J16	DEPN USIA EMPLOYEE	901000	DEP U	4-32	A3
J17	DEPN DRUG ENFCMNT AGNCY EMPL	901000	DEP D	4-32	A3
J18	DEPN DEPT INT CIV IN SAMOA	901000	D/CIV	4-22	A3

PATIENT CATEGORY	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY
J19	DEPN AG DEPT EMPLOYEE	901000	DEP U	4-27	SFA3
J21	FED EMP OCONUS & RMT CONUS	901000	DEP D	4-27	A3
J31	DEPN, EMPLOYEE FED AGENCY NEC	901000	DEP F	4-27	A3
K11	VETERANS ADMIN BENEFICIARIES	910000	VA BE	4-28	DDA1
K21	BENEFICIARIES OF OWCP	910000	OWCP	4-29	DDA1
K31	MBR US SOLDIERS/ARIMEN'S HOME	910000	MBR S	4-34	NC
K41	SOC SECY BENEFICIARY MEDICARE	910000	BENE	4-39	DDA1
K42	USPHS BENEFIT (AMER IND,ESK,ALEUT)	910000	BENE	4-30	DDA1
K43	TRUST TERR CIT (MICRONESIA,SAMOA)	910000	CIT M	4-40	SFA1
K44	TRUST TERR CIT (AMER SAMOA,NEC)	910000	CIT A	4-41	SFA1
K45	PEACE CORPS EMPL, MBR, APPL, DEPN	910000	PEACE	4-33	SFA1
K46	MERCHANT MARINE ACAD APPL	910000	MER M	4-6	DDA1
K47	USPHS STUDENT APPL	910000	USPHS	4-6	DDA1
K48	SECRET SVC PROTECTOR/EE	910000	PROT	4-42	SB
K49	BENE US CIVILIAN NEC	910000	BENE	4-27	A3
K51	US CIV SEAMEN, NOT MSTS/MSC	910000	SEAMA	4-46	NC
K52	US CIV EMPL OF US GOV CONTRTRS	910000	CREW	4-49	A3
K53	US CIV EMPL OF CONTRTRS PHY EX	910000	DOD C	4-50	SB
K61	US BENEF OF PRIV RLF ACTS OF CONG	910000	BENE	4-52	NC
K71	JOB CORPS BENEF, VISTA PERS	910000	BENE	4-38	DDA1
K72	PEACE ,VISTA,JOB CORPS NON BENEF	910000	PEC C	4-33 & 40	A3
K73	JOB CORPS/VISTA APPLICANT	910000	APPL	4-38	SFA1
M11	USMC AD OFFICER	110001	USMC	4-1	SB
M12	USMC AD ENLISTED	110001	USMC	4-1	SB
M21	USMC INITL ACDUTRA (REP 63) RES	110010	USMCT	4-2	SB
M22	USMC RES (<31 DAYS) ENLISTED	110001	USMCT	4-2	SB
M23	USMC RES (<31 DAYS) OFFICER	110001	USMCT	4-2	SB
M28	USMC NON-ACDUTRA RES ENLISTED	910001	USMCI	4-2	SB
M29	USMC NON-ACDUTRA RES OFFICER	910001	USMCI	4-2	SB
M31	USMC RET LOS OFFICER	210001	RET/U	4-11	SB
M32	USMC RET LOS ENLISTED	210001	RET/U	4-11	NC
M33	USMC PDRL OFFICER	210001	PDRL/	4-11	SB
M34	USMC PDRL ENLISTED	210001	PDRL/	4-11	NC
M41	USMC TDRL OFFICER	210001	TDRL/	4-11	SB
M42	USMC TDRL ENLISTED	210001	TDRL/	4-11	NC
M51	DEPN USMC AD SPONSOR	301000	DEP/A	4-12	B
M52	PREADOPT CHILD USMC AD SPONSOR	301000	PREAD	4-56	B
M61	DEPN USMC RET SPONSOR	301000	DEP/R	4-12	B
M62	DEPN USMC DECEASED SPONSOR	301000	DEP/D	4-12	B
M63	PREADOPT CHILD USMC RET SPON	301000	PREAD	4-56	B
N11	USN AD OFFICER	110001	USN	4-1	SB
N12	USN AD ENLISTED	110001	USN	4-1	SB
N21	USN INITL ACDUTRA (REP 63) RES	110001	USNT	4-2	SB
N22	USN RES (<31 DAYS) ENL	110001	USNT	4-2	SB
N23	USN RES (<31 DAYS) OFFICER	110001	USNT	4-2	SB
N28	USN NON-AD/ACDUTRA RES ENLISTED	910001	USNI	4-2	SB
N29	USN NON-AD/ACDUTRA RES OFFICER	910001	USNI	4-2	SB
N31	USN RET LOS OFFICER	210001	RET/N	4-11	SB
N32	USN RET LOS ENLISTED	210001	RET/N	4-11	NC
N33	USN PDRL OFFICER	210001	PDRL/	4-11	SB
N34	USN PDRL ENLISTED	210001	PDRL/	4-11	NC
N41	USN TDRL OFFICER	210001	TDRL/	4-11	SB
N42	USN TDRL ENLISTED	210001	TDRL/	4-11	NC
N51	DEPN USN AD SPONSOR	301000	DEP/A	4-12	B
N52	PREADOPT CHILD USN AD SPONSOR	301000	PREAD	4-56	B
N61	DEPN USN RET SPONSOR	301000	DEP/R	4-12	B

PATIENT CATEGORY	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY
N62	DEPN USN DEC SPONSOR	301000	DEP/D	4-12	B
N63	PREADOPT CHILD USN RET SPONSOR	301000	PREAD	4-56	B
N71	USN ACAD MIDSHIPMEN	110001	USNA	4-1	SFSB
N81	USN ROTC CADETS (OWN PAY)	110001	ROTC	4-4	A3
N82	USN ROTC CADET APPL	110010	ROTC	4-5	SFSB
O11	US NOAA ACT DUTY OFFICER	110001	NOAA	4-1	X
O12	US NOAA ACT DUTY ENLISTED	110001	NOAA	4-1	D7
O21	US NOAA RES (<31 DAYS) OFFICER	110001	NOAAT	4-2	X
O29	US NOAA NON-AD/ACDUTRA RES	910001	NOAAI	4-2	X
O31	US NOAA RET LOS OFFICER	110001	RET/N	4-11	X
O33	US NOAA PDRL OFFICER	210001	PDRL/	4-11	X
O41	US NOAA TDRL OFFICER	210001	TDRL/	4-11	X
O51	DEPN USNOA AD SPONSOR	301000	DEP/A	4-12	Y
O52	PREADOPT CHILD USNOA AD SPONSOR	301000	PREAD	4-56	
O61	DEPN USNOA RET SPONSOR	301000	DEP/R	4-12	Y
O62	DEPN USNOA DEC SPONSOR	301000	DEP/D	4-12	Y
O63	PREADOPT CHILD USNOA RET SPON	301000	PREAD	4-56	
P11	PHS AD OFFICER	110001	PHS	4-1	X
P21	USPHS RES (<31 DAYS) OFFICER	110001	PHST	4-2	X
P25	USPHS INACTIVE RES OFFICER	110001	PHSI	4-30	X
P29	USPHS NON-AD/ACDUTRA RES OFF	910001	PHSI	4-2	X
P31	USPHS RET LOS OFFICER	210001	RET/U	4-11	X
P33	USPHS PDRL OFFICER	210001	TDRL/	4-11	X
P41	USPHS TDRL OFFICER	210001	TDRL/	4-11	X
P51	DEPN USPHS AD SPONSOR	301000	DEP/A	4-12	Y
P52	PREADOPT CHILD USPHS AD SPON	301000	PREAD	4-56	Y
P61	DEPN USPHS RET SPONSOR	301000	DEP/R	4-12	Y
P62	DEPN USPHS DEC SPONSOR	301000	DEP/D	4-12	Y
P63	PREADOPT CHILD USPHS RET SPON	301000	PREAD	4-56	
Q11	PRISONERS OF WAR	910000	POW	4-43	SFSB
Q12	INTERNEES	910000	INTER	4-43	SFSB
Q13	RETAINED PERSONNEL	910000	RET P	4-43	SFSB
R11	OTH PRIS HOSP > SENTENCE EXP	910000	PRIS	4-43	A3
R12	PRIS-PNTIVE DISCHG-EXEC NOT EXP	910000	PRISO	4-43	SFSB
R13	NON-MIL FED PRISONERS	910000	NON-M	4-43	DDA1
R14	PERSONS IN MIL CUSTODY	910000	CUST	4-43	NC
S11	IMET TRAINEES, MIL, ENL	910000	IMET	4-23 OR 26	DDA2
S12	IMET TRAINEES, MIL, OFF	910000	IMET	4-23 OR 26	Z
S13	IMET TRAINEES, CIV	910000	IMET	4-23 OR 26	Z
S14	IMET TRAINEES OVERSEAS NEC	910000	IMET	4-23 OR 26	Z
S15	IMET ORIENTATION TOUR MEMBER	910000	IMET	4-23	Z
S16	FGN MIL SALES TRAINEES	910000	MIL S	4-23	A3
S21	FGN MIL DIPL,ENL	910000	MIL D	4-23	DDA3
S22	FGN MIL DIPL,OFF	910000	MIL D	4-23	W
S23	NATO MIL PERS, ENL	910000	NATO	4-23	NC
S24	NATO MIL PERS FGN NTL OFF	910000	NATO	4-23	W
S25	MIL,ALLIED/NEUT,US ARM FORC,ENL	910000	NON-N	4-23	DDA3
S26	MIL,ALLIED/NEUT,TRN ARM FORC,OFF	910000	NON-N	4-23	W
S27	MIL,ALLD/NEUT,NOT TRN ARM FOR,ENL	910000	NON-N	4-23	DDA3
S28	MIL,ALLIED/NEUT,NOT TRN ARM FO,OFF	910000	NON-N	4-23	W
S31	FGN NON-MIL DIPL, NEC	910000	NON-M	4-23	A3
S32	FOR NATL NATO CIV PER NEC	910000	NATO	4-23	A3
S33	FGN NTL KUWAIT STUDENT	910000	KUWAI	4-23	DDA3
S34	FOR NATL MEXICAN MIGRANT WORKER	910000	MEX W	4-30	DDA3
S35	SPEC FOR NATL OUTSIDE US	910000	SPEC	4-25	DDA3
S36	FGN NATL EMPL US UNIF SVCS	910000	EMP U	4-23	DDA3

PATIENT CATEGORY	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY
S37	FGN NTL AUTH CARE PER AGREEMENT	910000	FGN N	4-23	DDA1
S38	FGN NTL CIV PERS-LIA/NATO/CENTO	910000	LIA N	4-23	W
S39	FGN NTL EMP/DEPN US OCONUS, NEC	901000	FR NT	4-23	A3
S41	FGN NATL DEP MIL DIPLOMAT NEC	910000	DEP M	4-23	A3
S42	DEP NAT PERS TRN W/US ARM FOR	901000	DEP F	4-23	A3
S43	DEPN OTH NATO MIL PERS NOT TRAIN	901000	DEP F	4-23	A3
S44	FGN NATL DEF OF NON NATO TNG W/US	901000	DEP N	4-23	A3
S45	FG NAT DEP NON-NATO MIL NEC	901000	DEP N	4-23	A3
S46	DEPN FGN NTL MIL SALES TRAINEES	901000	DEP M	4-23	A3
S47	DEP FG NT MIL IN US FOR IMET, NEC	901000	DEP I	4-23	A3
S48	DEPN OTH FGN MIL PERS,NEC	901000	OTH F	4-23	A3
S51	DEPN FGN NTL NON-MIL DIPL,NEC	901000	DEP D	4-23	A3
S52	DEPN FGN NATO CIV PERS	901000	DEP N	4-23	A3
S53	DEPN FGN NTL NON-NATO CIV, NEC	901000	DEP N	4-23	A3
S54	DEPN AUTH FGN NTL IN US,NEC	901000	DEP F	4-23	A3
S55	DEPN AUTH FGN NTL, NEC	901000	DEP F	4-23	A3
S61	FGN NTL BENE OF DISASTR RELIF AGEN	910000	BENE	4-69	A3
S62	FGN NTL CRW/PAX NATO/CENTO ACRAFT	910000	FGN N	4-25	W
S63	FGN NTL DOD DOM ACT PROG PARTIC	910000	FGN N	4-63	DDA3
S64	FG NT PROV DIR SVC TO US FOR DEPN	910000	FGN N	4-25	A3
S65	FGN NTL DOMESTIC SERV OCONUS	910000	DOM S	4-62	A3
X11	APPL FOR CADET IN USMA	910000	APPL	4-6	SFSB
X12	APPL FOR CADET IN USNA	910000	APPL	4-6	SFSB
X13	APPL FOR CADET IN USAFA	910000	APPL	4-6	SFSB
X14	APPL FOR CADET IN USCGA	910000	APPL	4-6	DDA1
X15	APL/EN REENL IN ARM FOR,SEL SER	910000	APPL	4-7	SFSB
X16	APPL APPOINT/WARRANT/COMMISION NEC	910000	APPL	4-8	SB
X17	NON-SEL SVC REG FOR REEN NTL GD	910000	APPL	4-7	SFSB
X18	NON-SELEC SVC REG FOR REENL IN RSV	910000	APPL	4-7	SFSB
X19	APPL FOR APPT OCONUS BENE	910000	APPL	4-32	
X21	US CIV POW RELEAS FROM AD, OFF	910000	REFRA	4-66	SB
X22	US CIV POW RELEAS FROM AD, ENL	910000	REFRA	4-66	NC
X23	DEPN US CIV RET POW-FORMER SVC MBR	901000	DEP R	4-66	B
X31	US CIV CLAIMANT DOD	910000	CLAIM	4-52	NC
X32	USA CIV CLAIMANT	910000	CLAIM	4-52	NC
X33	USN CIV CLAIMANT	910000	CLAIM	4-52	NC
X34	USMC CIV CLAIMANT	910000	CLAIM	4-52	NC
X35	USAF CIV CLAIMANT	910000	CLAIM	4-52	NC
X36	CIV EMPL/OTH FED AGEN/NON-DOD,NEC	910000	CLAIM	4-52	DDA1
X41	RED CROSS EMPLOYEE	910000	EMP R	4-47	SB
X42	RED CROSS VOLUNTEERS	910000	VOL W	4-47	SB
X43	CIV STUDENT EMPL-RED CROSS	910000	EMP R	4-48	SB
X44	NB OF HONOR DSCHG FEMALE	901000	ND/DS	4-44	SB
X45	CIV SEAMAN IN SVC OF MSTS/MSC	910000	MSC S	4-46	DDA1
X46	US CIV AUTH CARE PER AGRMNT	910000	PER A	4-55	A3
X47	FORMER MBR CITIZEN MIL TRAIN CORP	910000	CIT M	4-3	SB
X48	US CIV-MIL SPONSOR ACTIV	910000	DOD A	4-51	SB
X49	CIV AUT/DC GOVT/JROTC/CAP/CGAUX	910000	JR RO	4-51	SB
X51	DEPN USO/RED CROSS	901000	DEP U	4-53	B
X52	DIVORC SPOUSE/RET MILITARY	901000	FORM	4-12	
X61	HONOR DSCHG FEMALE-MATERN CARE	910000	DSCHG	4-44	SB
X71	NON-INDIGENT CIVILIAN	910100	NON-I	4-59	A3
X72	INDIGENT CIVILIAN	910100	DOD I	4-59	NC
X73	NB INF DEPN DAUGHTER	910000	NB DE	4-44	A3
X74	VOLUN DONOR ORGAN/BLOOD NO CHG	910000	CIV D	4-76	NC
X75	VOLUN SUBJ RESEARCH PROJ	910000	VOL S	4-60	NC

PATIENT CATEGORY	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY
X76	NON DOD BENEFIT		NON-D	4-34	
X77	JOINT ORIENTATION CIV CONF GUEST	910000	CIV C	4-59	A3

PATIENT CATEGORY (NAVY)

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PATIENT CATEGORY / NAVY SHORT DESCRIPTION	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY ARMY	ENLISTED CHARGE CAT AIR FORCE	OFFICER CHARGE CAT AIR FORCE
A11 ACDU-A	USAR ACTIVE DUTY	11000101					
A12 ACDUTRA-A	USAR ACDUTRA	11000101					
A13 ACAD-CAD-A	USAR ACTIVE DUTY CADET	11000101					
A21 INACDUTRA-A	USAR INACDUTRA	11000101					
A22 RETACDUTRA-A	USAR RETAINED BEYOND ACDUTRA	11001101					
A31 RET-A-LOS	USAR RETIRED - LENGTH OF SERVICE	210001					
A32 RET-A-PDRL	USAR RETIRED - PDRL	210001					
A33 RET-A-TDRL	USAR RETIRED - TDRL	210001					
A41 DEP-ACDU-A	USAR AD DEPN	301000					
A42 DEP-RET-A	USAR DEPN RETIRED	301000					
A43 DEP-D-ACDU-A	USAR DEPN DECEASED AD	301000					
A44 DEP-D-RET-A	USAR DEPN DECEASED RETIRED	301000					
F11 ACDU-F	USAF ACTIVE DUTY	11000101					
F12 ACDUTRA-F	USAF ACTIVE DUTY TRAINING	11000101					
F13 ACAD-CAD-F	USAF ACTIVE DUTY CADET	11000101					
F21 INACDUTRA-F	USAF INACTIVE DUTY TRAINING	11000101					
F22 RETACDUTRA-C	USAF RET AD TRAINING	11001101					
F31 RET-F-LOS	USAF RETIRED LOS	210001					
F32 RET-F-PDRL	USAF RETIRED PDRL	210001					
F33 RET-F-TDRL	USAF RETIRED TDRL	210001					
F41 DEP-ACDU-F	DEPN USAF ACTIVE DUTY	301000					
F42 DEP-RET-F	DEPN USAF RETIRED	301000					
F43 DEP-D-ACDU-F	DEPN USAF DECEASED AD	301000					
F44 DEP-D-RET-F	DEPN USAF DECEASED RETIRED	301000					
H61 CIVEMP-NEC	US CIVILIAN EMPLOYEE NEC	910000					
H62 D-CIVEMP-NEC	DEPN US CIVILIAN EMPLOYEE NEC	301000					

PATIENT CATEGORY / NAVY SHORT DESCRIPTION	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY ARMY	ENLISTED CHARGE CAT AIR FORCE	OFFICER CHARGE CAT AIR FORCE
H63 FBI-CLAIMANT	FBI AGENTS FOR CLS AGAINST USG	910000					
H64 STDEPT-FSO	STATE DEPT-FSO FOR EMPLOYEE	910000					
H65 STDEPT-DEP	DEPN STATE DEPARTMENT	301000					
K71 VAB	VETERANS ADMIN BENEFICIARY	910000					
K72 OWCP	OFFICE OF WORKERS COMP PROG	910000					
K73 SECNAVDESG	SECRETARY OF NAVY DESIGNEE	910000					
K74 BENSOCSECADM	BENEFICIARIES OF SOC SECY ADMIN	910000					
K75 BENPHS	OTHER BENEFICIARIES PHS	910000					
K76 BENNAVHOME	BENEFICIARIES OF THE NAVAL HOME	910000					
K77 AOB-NEC	ALL OTHER BENEFICIARIES	910000					
M11 ACDU-MC	USMC ACTIVE DUTY	1100011					
M12 ACDUTRA-M	USMC ACTIVE DUTY TRAINING	11000101					
M14 AVIA-CAD-M	USMC AD AVIATION CADET	1100011					
M15 ACDU-MC-URT	USMC AD RECRUIT TRAINING	1100011					
M21 INACDUTRA-M	USMC INACTIVE DUTY TRAINING	11000101					
M22 RETACDUTRA-M	USMC RET AD TRAINING	11001101					
M31 RET-M-LOS	USMC RETIRED LOS	210001					
M32 RET-M-PDRL	USMC RETIRED PDRL	210001					
M33 RET-M-TDRL	USMC RETIRED TDRL	210001					
M41 DEP-ACDU-M	DEPN USMC ACTIVE DUTY	301000					
M42 DEP-RET-M	DEPN USMC RETIRED	301000					
M43 DEP-D-ACDU-M	DEPN USMC DECEASED AD	301000					
M44 DEP-D-RET-M	DEPN USMC DECEASED RET	301000					
N11 ACDU-N	USN ACTIVE DUTY	11000101					
N12 ACDUTRA-N	USN ACTIVE DUTY TRAINING	11000101					
N13 ACAD-CAD-N	USN ACTIVE DUTY ACAD CADET	11000101					

PATIENT CATEGORY (NAVY)

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PATIENT CATEGORY	DESCRIPTION / NAVY SHORT DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY ARMY	ENLISTED CHARGE CAT AIR FORCE	OFFICER CHARGE CAT AIR FORCE
N14	USN ACTIVE DUTY AVIATION CADET AVIA-CAD-N	11000101					
N15	USN AD RECRUIT TRAINING ACDU-N-URT	11000101					
N21	USN INACTIVE DUTY TRAINING INACDUTRA-N	11000101					
N22	USN RETAINED AD TRAINING RETACDUTRA-A	11001101					
N31	USN RETIRED LOS RET-NAV-LOS	210001					
N32	USN RETIRED PDRL RET-NAV-PDRL	210001					
N33	USN RETIRED TDRL RET-NAV-TDRL	210001					
N41	DEPN USN ACTIVE DUTY DEP-ACDU-N	301000					
N42	DEPN USN RETIRED DEP-RET-N	301000					
N43	DEPN USN DECEASED AD DEP-D-ACDU-N	301000					
N44	DEPN USN DECEASED RETIRED DEP-D-RET-N	301000					
O11	USNOA ACTIVE DUTY ACDU-NOAA	110001					
O31	USNOA RETIRED LOS RET-NOAA-LOS	210001					
O32	USNOA RETIRED PDRL RET-NOAA-PDR	210001					
O33	USNOA RETIRED TDRL RET-NOAA-TDR	210001					
O41	DEPN USNOA ACTIVE DUTY DEP-ACDU-NOA	301000					
O42	DEPN USNOA RETIRED DEP-RET-NOA	301000					
O43	DEPN USNOA DECEASED AD DEP-D-AC-NOA	301000					
O44	DEPN USNOA DECEASED RETIRED DEP-D-RE-NOA	301000					
P11	USCG ACTIVE DUTY ACDU-C	110001					
P12	USCG ACTIVE DUTY TRAINING ACDUTRA-C	110001					
P13	USCG ACTIVE DUTY ACAD CADET ACAD-CAD-C	110001					
P21	USCG INACTIVE DUTY TRAINING INACDUTRA-C	110001					
P22	USCG RETAINED AD TRAINING RETACDUTRA-C	11001101					
P31	USCG RETIRED LOS RET-C-LOS	210001					
P32	USCG RETIRED PDRL RET-C-PDRL	210001					

PATIENT CATEGORY / NAVY SHORT DESCRIPTION	DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY ARMY	ENLISTED CHARGE CAT AIR FORCE	OFFICER CHARGE CAT AIR FORCE
P33 RET-C-TDRL	USCG RETIRED TDRL	210001					
P41 DEP-ACDU-C	DEPN USCG ACTIVE DUTY	301000					
P42 DEP-RET-C	DEPN USCG RETIRED	301000					
P43 DEP-D-ACDU-C	DEPN USCG DECEASED AD	301000					
P44 DEP-D-RET-C	DEPN USCG DECEASED RETIRED	301000					
Q81 POW	PRISONER OF WAR	910000					
S51 NATO-AD	NATO ACTIVE DUTY	910000					
S52 DEP-NATO-AD	DEPN NATO ACTIVE DUTY	301000					
S53 ACDU-N-NATO	NON-NATO ACTIVE DUTY	910000					
S54 NON-NATO-DEP	DEPN NON-NATO	301000					
S58							
W11 ACDU-PHS	USPHS ACTIVE DUTY	110001					
W31 RET-PHS-LOS	USPHS RETIRED LOS	210001					
W32 RET-PHS-PDRL	USPHS RETIRED PDRL	210001					
W33 RET-PHS-TDRL	USPHS RETIRED TDRL	210001					
W41 DEP-ACDU-P	DEPN USPHS ACTIVE DUTY	301000					
W42 DEP-RET-P	DEPN USPHS RETIRED	301000					
W43 DEP-D-ACDU-P	DEPN USPHS DECEASED AD	301000					
W44 DEP-D-RET-P	DEPN USPHS DECEASED RETIRED	301000					
X82 MM-MIL-S-CMD	MERCHANT MARINE MIL SEALIFT CMMND	910000					
X83 MM-PRIV-PRTY	MERCHANT MARINE PRIVATE PARTY	910000					
X84	SELEC SVC REG/APPL ENL/REENL	910000					
X85 EXSVC-MATRNY	EX SERVICE MATERNITY	910000					
X86 AMER-RED-X	AMERICAN RED CROSS	910000					
X87 NON-IND-CIV	NON INDIGENT CIVILIAN	91010000					
X88 IND-CIV	INDIGENT CIVILIAN	91010000					

PATIENT CATEGORY (NAVY)

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PATIENT CATEGORY	DESCRIPTION / NAVY SHORT DESCRIPTION	FLAGS	BENEFICIARY SHORT DESC ARMY	AUTH FOR ADM	CHARGE CATEGORY ARMY	ENLISTED CHARGE CAT AIR FORCE	OFFICER CHARGE CAT AIR FORCE
X89	ALL OTHER NEC ALL-OTH-NEC	910000					

PRIM CARE PROVIDER (table) AUG 31,1985 19:41 PAGE 1

PRIM CARE PROVIDER CODE	DOCTOR NAME	SSN	DATE ASSIGNED TO MTF	SPECIALTY	AF ID CODE	DELETE DATE
BERNAR	BERNARD,EDWARD M.D.	256782522	03 JUN 1984	AAAC	356300	
BLACK	BLACK, JOHN	222314325	02 JAN 1985	AAAA		
BLACKB	BLACK,BRUCE	898478321	01 AUG 1984	ADB	889900	
BROWN	BROWN, MARCIA	998320932	01 MAR 1983	AAAA	884003	
DILLON	DILLON, JOHN	334998123	01 OCT 1982	ABA	903412	
FRED	FREDERICKS,WALTER	909847093	08 JUN 1985	AFA	223456	
HEAD	HEAD, DOC	232132154	23 SEP 1983	ABDA	440553	
HENRY	HENRY,O.	237649676	10 OCT 1984	AAAA		
JOHNS	JOHNS, MIKE	889031231	02 JAN 1985	AAJA	445222	
JONESB	JONES, BRADFORD, M.D.	115544221	18 MAR 1983	ACB		
JONESD	'JONES, DONALD, T, UROLOGIST	444224444	30 APR 1985	ABKA	123456	APR 30,1985
NEWKKK	NEW,KKK DOCTOR	239988773	01 APR 1983	ADBA		
NEWMAN	NEWMAN,PAUL	332244112	25 APR 1985	ABD	333333	
RILEY	RILEY, JAMES	231093412	12 APR 1984	AAAA	330442	
ROGERS	ROGERS,STEVEN J, OB/GYN	172654561	06 MAY 1983	ACB	000345	
STAFF	STAFF DOCTOR	011212111	03 JUN 1984	AAA	012222	
THOMAS	THOMAS, TOM	220931239	10 OCT 1981	AAAA	938493	
WHITE	WHITE, JAMES	334094412	01 MAR 1983	AAEA	440932	
WILLIA	WILLIAMS, HANK	990231231	01 MAR 1980	AAAA	098999	

MTF (MEDICAL TREATMENT FAC) LIST AUG 21,1985 06:49 PAGE 1

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
0055	VETERANS HOSPITAL (CONUS)		F
0066	ALL OTHER NON-MILITARY HOSPITALS (CONUS)		F
0071	WALTER REED AMC, WASHINGTON, DC 20301		F
0072	BROOKE AMC, FT SAM HOUSTON, TX 78234		F
0073	WILLIAM BEAUMONT AMC, FT BLISS, TX 79920		F
0074	FITZSIMONS AMC, DENVER, CO 80045		F
0075	LETTERMAN AMC, SAN FRANCISCO, CA 94129		F
0076	MADIGAN AMC, FT LEWIS, WA 98432		F
0077	ALL OTHER ARMY FACILITIES		F
0081	US NAVAL HOSP, ST ALBANS		F
0082	US NAVAL HOSP, PHILADELPHIA, PA 19112		F
0083	US NAVAL HOSP, GREAT LAKES, IL 60088		F
0084	US NAVAL HOSP, SAN DIEGO, CA 92133		F
0085	US NAVAL HOSP, CHELSA		F
0086	US NAVAL HOSP, PORTSMOUTH, VA 23708		F
0087	US NAVAL HOSP, CHARLESTON, SC 29408		F
0088	ALL OTHER NAVY FACILITIES (CONUS)		F
0099	CARDED FOR RECORD ONLY (CRO)(CONUS)	1	F
0101	TRIPLER AMC, OAHU, HI		A
0111	BASSETT ACH, FT WAINWRIGHT, AK		A
0121	GORGAS ACH, REP OF PANAMA		A
0155	USAF RGN HSP, MAXWELL AFB, AL 36112		F
0211	196TH STATION HOSP, SHAPE, BELGUIM		A
0251	USAF CLINIC, EIELSON AFB, AK 99702		F
0252	USAF RGN HOSP, ELMENDORF AFB, AK 99506		F
0311	USACH, BERLIN, GE		A
0311	225TH STA HOSP		A
0321	USACH, BREMERHAVEN, GE		A
0331	ARMC FRANKFURT, GE		A
0341	130TH STATION HOSP, HEIDELBERG, GE		A
0351	ARMC LANDSTUHL, GE		A
0361	USACH, NUERNBERG, GE		A
0371	USACH, BAD CANNSTATT, GY		A
0381	USACH, WUERZGERG, GE		A
0391	USACH, AUGSBURG, GE		A
03A1	7TH CSH		A
03B1	30TH FLD HOSP		A
03C1	31ST CSH		A
03D1	33D CSH		A
03E1	67TH EVAC HOSP		A
03F1	128TH CSH		A
03G1	130TH GEN HOSP		A
03H1	56TH GEN HOSP		A
03I1	225TH STA HOSP		A
03J1	279TH STA HOSP		A
0411	USACH, LEGHORN, ITALY		A
0421	USACH, VICENZA, ITALY		A
0451	AF HSP, DAVIS-MONTHAN AFB, AZ 85707		F
0452	USAF HOSPITAL, LUKE AFB, AZ 85309		F
0454	USAF HOSP, WILLIAMS AFB, AZ 85224		F
0456	59 TAC HOSP, LUKE AFB, AZ (TAC) 85309		F
0551	AF HOSP, BLYTHEVILLE AFB, AR 72315		F
0553	AF HOSP, LITTLE ROCK AFB, AR 72076		F
0611	121ST EVAC HOSP, SEOUL, KOREA		A
0652	USAF HOSPITAL, BEALE AFB, CA 95903		F
0653	USAF HOSPITAL, CASTLE AFB, CA 95342		F

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
0654	USAF HOSP, EDWARDS AFB, CA 93523		F
0655	USAF HOSP, GEORGE AFB, CA 92394		F
0658	USAF RGN HOSPITAL, MARCH AFB, CA 92518		F
0659	USAF HOSP, MATHER AFB, CA 95655		F
0661	AF CLINIC, MCCLELLAN AFB, CA 95652		F
0662	USAF CLINIC, NORTON AFB, CA 92409		F
0664	DAVID GRANT USAF MED CEN, TRAVIS AFB, CA 94535		F
0670	USAF HOSP, VANDENBERG AFB, CA 93437		F
0671	AF CLINIC, LOS ANGELES AFB, CA 90009		F
06A1	43D SURG HOSP		A
0855	USAF CLINIC HOSP, LOWRY AFB, CO 80230		F
0857	USAF ACADEMY HOSP, ACADEMY USAF, CO 80840		F
0860	USAF CLINIC, PETERSON AFB, CO 80914		F
1001	WALTER REED AMC, WASHINGTON DC 20301		A
1011	PROV RES HOSP, FT DRUM, NY		A
1021	DEWITT ACH, FT BELVOIR, VA		A
1031	WOMACK ACH, FT BRAGG, NC		A
1041	CUTLER ACH, FT DEVENS, MA		A
1051	USAF HOSPITAL, DOVER AFB, DE		F
1051	WALSON ACH, FT DIX, NJ		A
1061	MCDONALD ACH, FT EUSTIS, VA		A
1071	IRELAND ACH, FT KNOX, KY		A
1081	KENNER ACH, FT LEE, VA		A
1091	KIMBROUGH ACH, FT MEADE, MD		A
1111	PATTERSON ACH, FT MONMOUTH, NJ		A
1121	KELLER ACH, WEST POINT, NY		A
1131	HAWLEY ACH, FT BENJAMIN HARRISON, IN		A
11A1	5TH CSH		A
11B1	10TH CSH		A
11C1	15TH CSH		A
11D1	28TH CSH		A
11E1	43D SURG HOSP		A
11F1	46TH CSH		A
11G1	85TH CSH		A
1201	FITZSIMONS AMC, DENVER, CO		A
1211	CARSON ACH, FT. CARSON, CO.		A
1221	MUNSON ACH, FT LEAVENWORTH, KS		A
1231	GEN LEONARD WOOD ACH, FT LEONARD WOOD, MO		A
1241	IRWIN ACH, FT RILEY, KS		A
1251	USACH, FT SHERIDAN, IL		A
1252	USAF RGN HOSP, EGLIN AFB, FL 32542		F
1253	AF RGN HOSP, MACDILL AFB, FL 33608		F
1256	USAF HOSP, PATRICK AFB, 32925		F
1258	USAF HOSP, TYNDALL AFB, FL 32403		F
1261	PROV RES HOSP, FT MCCOY, WI		A
1263	USAF HOSP, HOMESTEAD AFB, FL 33039		F
12A1	16TH CSH		A
12B1	93D EVAC		A
1301	DDEAMC, FT GORDON, GA		A
1311	MARTIN ACH, FT BENNING, BA		A
1321	BLANCHFIELD ACH, FT CAMPBELL, KY		A
1331	MONCRIEF, ACH, FT JACKSON, SC		A
1341	NOBEL ACH, FT MCCLELLAN, AL		A
1351	FOX ACH, REDSTONE ARSENAL, AL		A
1355	USAF HOSPITAL, MOODY AFB, GA 31601		F
1356	USAF HOSPITAL, ROBINS AFB, GA 31098		F

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
1361	LYSTER ACH, FT RUCKER, AL		A
1371	WINN ACH, FT STEWART, GA		A
13A1	2D CSH		A
13B1	4TH CHS		A
13C1	86TH CSH		A
1401	BROOKE AMC, FT SM HOUSTON, TX		A
1411	DARNALL ACH, FT HOOD, TX		A
1421	BAYNE-JONES ACH, FT POLK, LA		A
1431	REYNOLDS ACH, FT SILL, OK		A
14A1	21ST EVAC HOSP		A
14B1	41ST CSH		A
14C1	47TH FLD HOSP		A
1501	WM BEAUMONT AMC, BT BLISS, TX		A
1511	R.W. BLISS ACH, FT HUACHUCA, AZ		A
1551	USAF CLINIC, HICKAN AFB, HI 96853		F
1601	LETTERMAN AMC, SF, CA		A
1611	SILAS B HAYS ACH, FT ORD, CA		A
1631	WEED ACH, FT IRWIN, CA		A
1651	AF HSP, MOUNTAIN HOME AFB, ID 83648		F
16A1	8TH CSH		A
1701	MADIGAN AMC, FT LEWIS, WA		A
1752	USAF HOSP, CHANUTE AFB, IL 61868		F
1756	USAF MED CTR, SCOTT AFB, IL 62225		F
17A1	47TH CSH		A
1854	USAF CLINIC, GRISSOM AFB, IN 46971		F
2057	USAF HOSP, MCCONNELL AFB, KS 67221		F
2251	USAF HOSP, ENGLAND AFB, LA 71301		F
2252	USAF HOSP, BARKSDALE AFB, LA 71110		F
2256	23 TAC HOSP, ENGLAND AFB, LA (TAC) 71301		F
2352	USAF HOSP, LORING AFB, ME 04751		F
2451	MALCOLM-GROW MED CTR, ANDREWS AFB, WASH DC 20331		F
2551	USAF CLINIC, HANSCOM AFB, MA 01731		F
2652	USAF HOSP, WURTSMITH AFB, MI 48753		F
2656	USAF HOSP, K I SAWYER AFB, MI 49843		F
2851	USAF HOSP, COLUMBUS AFB, MS 39701		F
2853	USAF MED CTR, KEESLER AFB, MS 39534		F
2954	USAF HOSP, WHITEMAN AFB, MO 65305		F
3051	USAF HOSP, MALMSTROM AFB, MT 59402		F
3151	EHRLING BERGQUIST USAF RGN HOSP, OFFUTT AFB, NE 68113		F
3251	USAF HOSP, NELLIS AFB, NV 89191		F
3352	USAF HOSP, PEASE AFB, NH 03801		F
3453	USAF CLINIC, MCGUIRE AFB, NJ 08641		F
3551	USAF HOSP, HOLLOMAN AFB, NM 88330		F
3552	USAF HOSP, KIRTLAND AFB, NM 87117		F
3554	UASF HOSPITAL, CANNON AFB, NM 88101		F
3557	49 TAC HOSP, HOLLOMAN AFB, NM (TAC) 88330		F
3653	USAF HOSP, GRIFFISS AFB, NY 13441		F
3663	USAF HOSP, PLATTSBURGH AFB, NY 12903		F
3752	USAF CLINIC, POPE AFB, NC 28308		F
3753	USAF HOSP, SEYMOUR JOHNSON AFB, NC 27531		F
3851	USAF HOSP, GRAND FORKS AFB, ND 58205		F
3852	USAF RGN HOSP, MINOT AFB, ND 58701		F
3954	USAF MED CEN, WRIGHT-PATTERSON, WPAFB, OH 45433		F
4052	USAF HOSP, TINKER AFB, OK 73145		F
4053	USAF CLINIC, VANCE AFB, OK 73701		F
4053	VA HOSPITAL WASHINGTON		A

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
4057	USAF HOSPITAL, ALTUS AFB, OK 73521		F
4552	USAF HOSP, SHAW AFB, SC 29152		F
4553	AF CLINIC, CHARLESTON AFB, SC 29404		F
4554	AF HOSP, MYRTLE BEACH AFB, SC 29577		F
4555	354 TAC HOSP, MYRTLE BEACH AFB, SC (TAC) 29152		F
4651	USAF HOSP, ELLSWORTH AFB, SD 57706		F
4852	USAF HOSP, BERGSTROM AFB, TX 78743		F
4855	USAF CLINIC, BROOKS AFB, TX 78235		F
4857	AF RGN HOSP, CARSWELL AFB, TX 76127		F
4860	AF CLINIC, GOODFELLOW AFB, TX 76908		F
4864	USAF CLINIC, KELLY AFB, TX 78241		F
4865	WILFORD HALL MED CTR, LACKLAND AFB, TX 78236		F
4868	AF CLINIC, RANDOLPH AFB, TX 78148		F
4869	USAF HOSP, REESE AFB, TX 79489		F
4871	AF RGN HOSP, SHEPPARD AFB, TX 76311		F
4877	USAF HOSP, LAUGHLIN AFB, TX 78840		F
4879	USAF HOSPITAL, DYESS AFB, TX 79607		F
4951	USAF HOSPITAL, HILL AFB, UT 84406		F
5151	USAF HOSP, LANGLEY AFB, VA 23665		F
5152	1ST TAC HOSP, LANGLEY AFB, VA (TAC) 23655		F
5351	USAF HOSP, FAIRCHILD AFB, WA 99011		F
5354	USAF CLINIC, MCCHORD AFB, WA 98438		F
5652	USAF HOSP, F E WARREN AFB, WY 82001		F
A201	AMC FITZSIMMONS, DENVER, CO		N
A202	AMC WM BEAUMONT, EL PASO, TX		N
A203	AH DEWITT, FT BELVOIR, VA		N
A204	AH MARTIN, FT BENNING, GA		N
A205	AH WOMACK, FT BRAGG, NC		N
A206	USAH FT CAMPBELL, KY		N
A207	USAH FT CARSON, CO		N
A208	AH CUTLER, FT DEVENS, MA		N
A209	AH WALSON, FT DIX, NJ		N
A210	AH MCDONALD, FT EUSTIS, VA		N
A211	AH KIMBROUGH, FT GEORGE G MEADE, MD		N
A212	AMC D D EISENHOWER, FT GORDON, GA		N
A213	AH DARNALL, FT HOOD, TX		N
A214	AH RAYMOND W BLISS, FT HUACHUCA, AR		N
A215	AH MONCRIEF, FT JACKSON, SC		N
A216	AH BASSETT, FT JONATHAN M WAINWRIGHT, AK		N
A217	AH IRELAND, FT KNOX, KY		N
A218	AH MUNSON, FT LEAVENWORTH, KS		N
A219	AH KENNER, FT LEE, VA		N
A220	AH GEN L WOOD, FT LEONARD WOOD, MO		N
A221	AH NOBLE, FT MCCLELLAN, AL		N
A222	AH PATTERSON, FT MONMOUTH, NJ		N
A223	AH SILAS B HAYES, FT ORD, CA		N
A224	USAH FT POLK, LA		N
A225	AH FOX, REDSTONE ARSENAL, AL		N
A226	AH IRWIN, FT RILEY, KS		N
A227	AH LYSTER, FT RUCKER, AL		N
A228	AHC BROOKE, FT SAM HOUSTON, TX		N
A229	AH REYNOLDS, FT SILL, OK		N
A230	USAH FT STEWART, GA		N
A231	AMC TRIPLER, HONOLULU, HI		N
A232	AMC LETTERMAN, SAN FRANCISCO, CA		N
A233	AMC MADIGAN, TACOMA, WA		N

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
A234	AMC WALTER REED, WASHINGTON, DC		N
A235	AH KELLER, WEST POINT, NY		N
A299	ALL OTHER ARMY UNITED STATES		N
A301	USAH AUGSBURG, GERMANY		N
A302	USAH BAD CANNSTATT, GERMANY		N
A303	USAH BERLIN, GERMANY		N
A304	USAH BREMERHAVEN, GERMANY		N
A305	USAH FRANKFURT, GERMANY		N
A306	USAH HEIDELBERG, GERMANY		N
A307	USAH LANDSTUHL, GERMANY		N
A308	USAH LEGHORN, ITALY		N
A309	USAH NURNBERG, GERMANY		N
A310	USAH SEOUL, KOREA		N
A311	USAH SHAPE, BELGIUM		N
A312	USAH VICENZA, ITALY		N
A313	USAH WURZBURG, GERMANY		N
A399	ALL OTHER ARMY OUTSIDE US		N
C699	CIVILAN INPATIENT MED TREATMENT FAC U S		N
C799	CIVILIAN INPATIENT MED TREATMENT FAC OUTSIDE U S		N
F401	USAF ACADEMY HOSP, CO		N
F402	USAF HOSP, ALTUS, OK		N
F403	MALCOLM GROW USAF MED CEN, WASHINGTON, DC		N
F404	USAF HOSP, BARKSDALE, LA		N
F405	USAF HOSP, BEALE, CA		N
F406	USAF HOSP, BERGSTROM, TX		N
F407	USAF HOSP, BLYETHVILLE, AR		N
F408	USAF HOSP, CANNON, NM		N
F409	USAF REGIONAL HOSP, CARSWELL, TX		N
F410	USAF HOSP, CASTLE, CA		N
F411	USAF HOSP, CHANUTE, IL		N
F412	USAF HOSP, COLUMBUS, MS		N
F413	USAF HOSP, DAVIS-MONTHAN, AZ		N
F414	USAF HOSP, DOVER, DE		N
F415	USAF HOSP, DYESS, TX		N
F416	USAF HOSP, EDWARDS, CA		N
F417	USAF REGIONAL HOSPITAL, EGLIN, FL		N
F418	USAF HOSP, ELLSWORTH, SD		N
F419	USAF HOSP, ELMENDORF, AK		N
F420	USAF HOSP, ENGLAND, LA		N
F421	USAF HOSP, FAIRCHILD, WA		N
F422	USAF HOSP, F E WARREN, WY		N
F423	USAF HOSP, GEORGE, CA		N
F424	USAF HOSP, GRAND FORKS, ND		N
F425	USAF HOSP, GRIFFISS, NY		N
F426	USAF HOSP, HILL, VT		N
F427	USAF HOSP, HOLLOMAN, NM		N
F428	USAF HOSP, HOMESTEAD, FL		N
F429	USAF MEDICAL CENTER, KEESLER, MS		N
F430	USAF HOSP, KIRTLAND, NM		N
F431	USAF HOSP, K I SAWYER, MI		N
F432	WILFORD HALL USAF MED CEN (LACKLAND AFB), TX		N
F433	USAF HOSP, LANGLEY AFB, VA		N
F434	USAF HOSP, LAUGHLIN, TX		N
F435	USAF HOSP, LITTLE ROCK, AR		N
F436	USAF HOSP, LORING, ME		N
F437	USAF HOSP, LUKE, AZ		N

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
F438	USAF REGIONAL HOSP, MACDILL, FL		N
F439	USAF HOSP, MALSTROM, MT		N
F440	USAF REGIONAL HOSP, MARCH, CA		N
F441	USAF HOSP, MATHER, CA		N
F442	USAF REGIONAL HOSP, MAXWELL, AL		N
F443	USAF HOSP, MCCONNELL, KS		N
F444	USAF REGIONAL HOSP, MINOT, ND		N
F445	USAF HOSP, MOODY, GA		N
F446	USAF HOSP, MOUNTAIN HOME, ID		N
F447	USAF HOSP, MYRTLE BEACH, SC		N
F448	USAF HOSP, NELLIS, NV		N
F449	EHRLING BERGQUIST USAF REG HOSP (OFFUTT AFB), NE		N
F450	USAF HOSP, PATRICK, FL		N
F451	USAF HOSP, PEASE, NH		N
F452	USAF HOSP, PLATTSBURG, NY		N
F453	USAF HOSP, REESE, TX		N
F454	USAF HOSP, ROBINS, GA		N
F455	USAF MED CEN, SCOTT, IL		N
F456	USAF HOSP, SEYMOUR JOHNSON, NC		N
F457	USAF REGIONAL HOSP, SHAW, SC		N
F458	USAF REGIONAL HOSP, SHEPPARD, TX		N
F459	USAF HOSP, TINKER, OK		N
F460	DAVID GRANT USAF MED CEN (TRAVIS AFB), CA		N
F461	USAF HOSP, TYNDALL, FL		N
F462	USAF HOSP, VANDENBURG, CA		N
F463	USAF HOSP, WHITEMAN, MO		N
F464	USAF HOSP, WILLIAMS, AZ		N
F465	USAF MED CEN, WRIGHT-PATTERSON AFB, OH		N
F466	USAF HOSP, WURTSMITH, MI		N
F499	ALL OTHER AIR FORCE US		N
F501	USAF HOSP, BITBURG, GE, APO NY 09132		N
F502	USAF HOSP, CLARK, PHILIPPINES, APO SF 96432		N
F503	USAF HOSP, HAHN, GE, APO NY 09109		N
F504	USAF HOSP, ATHENS, GREECE, APO NY 09223		N
F505	TUSLOG DET 47 - TURKEY, APO NY 09289		N
F506	USAF HOSP, IRAKLION, CRETE, APO NY 09291		N
F507	USAF HOSP, KUNSAN, KOREA, APO SF 96264		N
F508	USAF HOSP, LAJES, AZORES, APO NY 09406		N
F509	USAF HOSP, MISAWA, JAPAN, APO SF 96519		N
F510	USAF HOSPC, OSAN, KOREA, APO SF 96570		N
F511	USAF HOSP, LAKENHEATH, ENGLAND, APO NY 09179		N
F512	USAF HOSP, UPPER HEYFORD, ENGLAND, APO NY 09194		N
F513	USAF HOSP, TORREJON, SPAIN, APO NY 09283		N
F514	USAF REGIONAL MED CEN, WIESBADEN, GE, APO NY 09220		N
F515	USAF HOSP, YOKOTA, JAPAN, APO SF 96328		N
F599	ALL OTHER AIR FORCE OUTSIDE U S		N
GE50	OTHER EUROPE		F
GE55	AF CLINIC RHEIN-MAIN, APO NY 09057		F
GE56	USAF RGN MED CEN WIESBADEN, APO NY 09220		F
GE59	USAF HOSP BITBURG, APO NY 09132		F
GE60	USAF HOSPITAL HAHN, APO NY 09109		F
GE61	USAF CLINIC SEMBACH, APO NY 09130		F
GE62	AF CLINIC SPANGDAHLEM, APO NY 09123		F
GE64	USAF CLINIC RAMSTEIN, APO NY 09012		F
GE73	AF CLIN ZWEIBRUCKEN, APO NY 09860		F
GE74	50 TAC HOSP (HAHN), APO NY 09109		F

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
GE75	86 TAC HOSP (RAMSTEIN), APO NY 09012		F
GE76	36 TAC HOSP (BITBURG), APO NY 09132		F
GQ51	USAF CLINIC ANDERSON, APO SF 96334		F
GR51	USAF HOSP HELLENIKON, APO NY 09223		F
GR53	USAF HOSP IRAKLION, APO NY 09291		F
IT52	USAF CLINIC AVIANO, APO NY 09293		F
IT54	SAN VITO DEI NORMANNI USAF CLINIC, APO NY 09240		F
JA50	OTHER JAPAN AND OKINAWA		F
JA56	USAF HOSPITAL MISAWA, APO SF 96519		F
JA63	USAF HOSPITAL YOKOTA, APO SF 96328		F
JA71	655 TAC HOSP (YOKOTA), APO SF 09328		F
JA73	USAF CLINIC KADENA, APO SF 96239		F
KS54	USAF HOSPITAL KUNSAN, APO SF 96264		F
KS55	USAF HOSPITAL OSAN, APO SF 96570		F
N001	NS ADAK, AK		N
N002	NH BEAUFORT, SC		N
N003	NH BETHESDA, MD		N
N004	NAVHOSP BREMERTON, WA		N
N005	NAVHOSP CAMP LEJEUNE, NC		N
N006	NAVHOSP CAMP PENDLETON, CA		N
N007	NAVHOSP CHARLESTON, SC		N
N008	NH CHERRY POINT, NC		N
N009	NAVHOSP CORPUS CHRISTI, TX		N
N010	NAVHOSP GREAT LAKES, IL		N
N011	NAVHOSP JACKSONVILLE, FL		N
N012	NAVHOSP LEMOORE, CA		N
N013	NAVHOSP LONGBEACH, CA		N
N014	NAVHOSP MILLINGTON, MEMPHIS, TN		N
N015	NAVHOSP GROTON, NEW LONDON, CT		N
N016	NAVHOSP NEWPORT, RI		N
N017	NAVHOSP OAKLAND, CA		N
N018	NH ORLANDO, FL		N
N019	NTC ORLANDO, FL		N
N020	NAVHOSP PATUXENT RIVER, MD		N
N021	NARMC PENSACOLA, FL		N
N022	NH PHILADELPHIA, PA		N
N023	NH PORTSMOUTH, VA		N
N024	NH SAN DIEGO, CA		N
N026	BR HOSP 29 PALMS, CA		N
N027	NH WHIDBEY ISLAND, WA		N
N099	ALL OTHER US		N
N101	USNAVHOSP GUAM, MARIANA ISLANDS		N
N102	USNAVHOSP GUANTANAMO BAY, CUBA		N
N103	USMCAS IWAKUNI, JAPAN		N
N104	USNAVHOSP KEFLAVIK, ICELAND		N
N105	USNS MIDWAY ISLAND		N
N106	USNAVHOSP NAPLES, ITALY		N
N107	USNAVHOSP, OKINAWA, JAPAN		N
N108	USNAVHOSP ROOSEVELT ROADS, PUERTO RICO		N
N109	USNAVHOSP ROTA, SPAIN		N
N110	USNAF, SIGONELLA, ITALY		N
N111	USNAVHOSP SUBIC BAY, PHILIPPINE ISLANDS		N
N112	USNAVHOSP YOKOSUKA, JAPAN		N
N198	ALL US NAVAL SHIPS		N
N199	ALL OTHERS OUTSIDE US		N
NL51	CAMP NEW AMSTERDAM USAF CLINIC APO NY 09292		F

PRIMARY CARE MTF	DESCRIPTION	FLAGS	SERVICE FLAG
P050	OTHER CANAL ZONE		F
P051	USAF HOSPITAL LAJES, APO NY 09406		F
P899	PUBLIC HEALTH SERVICE MED TREATMENT FACILITY		N
PQ51	USAF CLINIC HOWARD, APO MIAMI 34001		F
RP35	657 TAC HOSP (CLARK), APO SF 96432		F
RP50	OTHER PHILLIPINES		F
RP51	AF RGN MED CTR CLARK, APO SF 96432		F
RP54	656 TAC HOSP (CLARK), APO SF 96432		F
SP51	USAF HOSP TORREJON, APO NY 09283		F
SP53	USAF CLINIC ZARAGOZA, APO NY 09286		F
SP74	401 TAC HOSP (TORREJON), APO NY 09283		F
UK53	AF CLINIC BENTWATERS, APO NY 09755		F
UK59	AF HOSP LAKENHEATH, APO NY 09179		F
UK63	AF HOSP UPPER HEYFORD, APO NY 09194		F
UK65	AF CLINIC CHICKSANDS, APO NY 09193		F
UK73	AF CLINIC ALCONBURY, APO NY 09238		F
UK81	48 TAC HOSP (LAKENEATH), APO NY 09179		F
UK82	20 TAC HOSP (UPPER HEYFORD), APO NY 09194		F
V899	VETERANS ADMINISTRATION MED TREATMENT FAC		N
XX55	VETERANS ADMINISTRATION HOSPITAL		F
XX66	ALL OTHER NON-MILITARY HOSPITALS		F
XX67	GORGAS AH, CANAL ZONE		F
XX77	ARMY FACILITIES		F
XX88	NAVY FACILITIES		F
XX99	CARDED FOR RECORD ONLY (OVERSEAS)	1	F
Z799	ALL OTHER NON-MILITARY OUTSIDE U S		N
Z899	ALL OTHER NON-MILITARY U S		N

RANK CODES AUG 31,1985 19:17 PAGE 1

RANK CODE	DESCRIPTION	COAST GUARD PAYGRADE	AIR FORCE PAYGRADE	MARINE PAYGRADE	NAVY PAYGRADE	OCEANAGRAPHIC PAYGRADE	PHS PAYGRADE	ARMY PAYGRADE
1LT	FIRST LIEUTENANT		O2	O2				O2
1SG	FIRST SERGEANT			E8				E8
2LT	SECOND LIEUTENANT		O1	O1				O1
A1C	AIRMAN FIRST CLASS		E3					
AB	AIRMAN BASIC		E1					
ADM	ADMIRAL	G4,10			G4,10	G4,10	G4,10	
AMN	AIRMAN		E2					
BG	BRIGADIER GENERAL		G1,07	G1,07				G1,07
CDA	AVIATION CADET	CD	CD	CD	CD,C1			CD
CDM	ACADEMY CADET/MIDSHIPMAN	CD	CD	CD	CD,M1			CD
CDR	COMMANDER	O5			O5	O5	O5	
CDT	CADET	CD	CD	CD	CD			CD
CIV	RANK FOR CIVILIAN EMERGENCY							
CMS	CHIEF MASTER SERGENT		E9					
COL	COLONEL		O6	O6				O6
COM	COMMODORE	G1,07			G1,07	G1,07	G1,07	
CPL	CORPORAL			E4				E4
CPO	CHIEF PETTY OFFICER	E7			E7			
CPT	CAPTAIN	O6	O3	O3	O6	O6	O6	O3
CSM	COMMAND SARGEANT MAJOR							E9
CW2	CHIEF WARRANT OFFICER	W2	W2	W2	W2			W2
CW3	CHIEF WARRANT OFFICER	W3	W3	W3	W3			W3
CW4	CHIEF WARRANT OFFICER	W4	W4	W4	W4			W4
DA	DENTAL APPRENTICE				E2			
DN	DENTAL SEAMAN				E3			
DR	DENTAL RECRUIT				E1			
ENS	ENSIGN	O1			O1	O1	O1	
FA	FLEET ADMIRAL	G5,10			G5,10	G5,10	G5,10	
GA	GENERAL OF THE ARMY							G5,10
GAF	GENERAL OF THE AIR FORCE		G5,10					
GEN	GENERAL		G4,10	G4,10				G4,10
GSG	GUNNERY SERGEANT			E7				
HA	HOSPITALMAN APPRENTICE				E2			
HN	HOSPITALMAN				E3			
HR	HOSPITALMAN RECRUIT				E1			
LCM	LIEUTENANT COMMANDER	O4			O4	O4	O4	
LCP	LANCE CORPORAL			E3				
LT	LIEUTENANT	O3			O3	O3	O3	
LTC	LIEUTENANT COLONEL		O5	O5				O5
LTG	LIEUTENANT GENERAL		G3,09	G3,09				G3,09
LTJ	LIEUTENANT JUNIOR GRADE	O2			O2	O2	O2	
MAJ	MAJOR		O4	O4				O4
MCP	MASTER CHIEF PETTY OFFICER	E9			E9			
MG	MAJOR GENERAL		G2,08	G2,08				G2,08
MGS	MASTER GUNNERY SGT			E9				
MSG	MASTER SERGEANT		E7	E8				E8
PFC	PRIVATE FIRST CLASS			E2				E3
PO1	PETTY OFFICER FIRST CLASS	E6			E6			
PO2	PETTY OFFICER SECOND CLASS	E5			E5			
PO3	PETTY OFFICER THIRD CLASS	E4			E4			
PSG	PLATOON SARGEANT							E7
PV1	PRIVATE							E1
PV2	PRIVATE							E2
PVT	PRIVATE			E1				
RAD	REAR ADMIRAL	G2,08			G2,08	G2,08	G2,08	
SA	SEAMAN APPRENTICE	E2			E2			

RANK CODE	DESCRIPTION	COAST GUARD PAYGRADE	AIR FORCE PAYGRADE	MARINE PAYGRADE	NAVY PAYGRADE	OCEANAGRAPHIC PAYGRADE	PHS PAYGRADE	ARMY PAYGRADE
SCP	SENIOR CHIEF PETTY OFFICER	E8			E8			
SFC	SERGEANT FIRST CLASS							E7
SGM	STAFF SERGEANT MAJOR			E9				E9
SGT	SERGEANT		E4	E5				E5
SMA	SERGEANT MAJOR OF THE ARMY							E9
SMS	SENIOR MASTER SERGEANT		E8					
SN	SEAMAN	E3			E3			
SP4	SPECIALIST 4							E4
SP5	SPECIALIST 5							E5
SP6	SPECIALIST 6							E6
SP7	SPECIALIST 7							E7
SR	SEAMAN RECRUIT	E1			E1			
SRA	SENIOR AIRMAN		E4					
SSG	STAFF SERGEANT		E5	E6				E6
SSM	STAFF SERGEANT MAJOR							E9
TSG	TECHNICAL SERGEANT		E6					
VAD	VICE ADMIRAL	G3,09			G3,09	G3,09	G3,09	
WO1	WARRANT OFFICER	W1	W1	W1	W1			W1

AERONAUTICAL RATING LIST AUG 21,1985 07:10 PAGE 1

AERONAUTICAL RATING CODE	DESCRIPTION	SERVICE FLAG
0	NO DESIGNATION	AF
1	AVIATION MEDICAL OFFICER	A
2	FLIGHT NURSE	AF
3	SENIOR FLIGHT NURSE	AF
4	CHIEF FLIGHT NURSE	AF
9	UNKNOWN DESIGNATOR	F
A	MASTER ARMY AVIATOR OR COMMAND PILOT	AF
B	SENIOR ARMY AVIATOR OR SENIOR PILOT	AF
C	ARMY AVIATOR OR PILOT	AF
D	MASTER AIRCRAFT OBSERVER	AF
E	SENIOR AIRCRAFT OBSERVER	AF
F	AIRCRAFT OBSERVER	AF
J	MASTER NAVIGATOR	AF
K	SENIOR NAVIGATOR	AF
L	NAVIGATOR	AF
P	CHIEF FLIGHT SURGEON	AF
Q	SENIOR FLIGHT SURGEON	AF
R	FLIGHT SURGEON	AF
S	COMMAND PILOT ASTRONAUT	AF
T	SENIOR PILOT ASTRONAUT	AF
U	PILOT ASTRONAUT	AF
X	OTHER RATING OR DESIGNATION (CREW MEMBER)	AF
Y	NO RATING OR DESIGNATION	AF
Z	UNKNOWN RATING	AF

CODE NUMBER	FMP CODE	DESCRIPTION	SERVICE FLAG	FLAGS
100	00	CIVILIAN EMERGENCY	A	31
1	01	OLDEST DEP CHILD	AFN	1
2	02	SECOND OLDEST DEP CHILD	AFN	1
3	03	THIRD OLDEST DEP CHILD	AFN	1
4	04	FOURTH OLDEST DEP CHILD	AFN	1
5	05	FIFTH OLDEST DEP CHILD	AFN	1
6	06	SIXTH OLDEST DEP CHILD	AFN	1
7	07	SEVENTH OLDEST DEP CHILD	AFN	1
8	08	EIGHTH OLDEST DEP CHILD	AFN	1
9	09	NINTH OLDEST DEP CHILD	AFN	1
10	10	TENTH OLDEST DEP CHILD	AFN	1
11	11	ELEVENTH OLDEST DEP CHILD	AFN	1
12	12	TWELFTH OLDEST DEP CHILD	AFN	1
13	13	THIRTEENTH OLDEST DEP CHILD	AFN	1
14	14	FOURTEENTH OLDEST DEP CHILD	AFN	1
15	15	FIFTEENTH OLDEST DEP CHILD	AFN	1
16	16	SIXTEENTH OLDEST DEP CHILD	AFN	1
17	17	SEVENTEENTH OLDEST DEP CHILD	AFN	1
18	18	EIGHTEENTH OLDEST DEP CHILD	AFN	1
19	19	NINETEENTH OLDEST DEP CHILD	AFN	1
20	20	SPONSOR	AFN	3
30	30	SPOUSE/FORMER SPOUSE	AFN	1
31	31	SPOUSE/FORMER SPOUSE	AFN	1
32	32	SPOUSE/FORMER SPOUSE	AFN	10
33	33	SPOUSE/FORMER SPOUSE	AFN	10
34	34	SPOUSE/FORMER SPOUSE	AFN	10
35	35	SPOUSE/FORMER SPOUSE	AFN	10
36	36	SPOUSE/FORMER SPOUSE	AFN	10
37	37	SPOUSE/FORMER SPOUSE	AFN	10
38	38	SPOUSE/FORMER SPOUSE	AFN	10
39	39	SPOUSE/FORMER SPOUSE	AFN	10
40	40	MOTHER/STEP-MOTHER	AFN	1
45	45	FATHER/STEP-FATHER	AFN	1
50	50	MOTHER-IN-LAW OF SPONSOR	AFN	1
55	55	FATHER-IN-LAW OF SPONSOR	AFN	1
60	60	1ST AUTH SPON DEP	AFN	1
61	61	2ND AUTH SPON DEP	AFN	1
62	62	3RD AUTH SPON DEP.	AFN	10
63	63	4TH AUTH SPON DEP	AFN	10
64	64	5TH AUTH SPON DEP	AFN	10
65	65	6TH AUTH SPON DEP	AFN	10
66	66	7TH AUTH SPON DEP	AFN	10
67	67	8TH AUTH SPON DEP	AFN	10
68	68	9TH AUTH SPON DEP	AFN	10
69	69	10TH AUTH SPON DEP	AFN	10
98	98	CIVILIAN EMERGENCY	FN	31
99	99	OTHERS	AFN	30

UNIT/SHIP ID

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UNIT ID CODE (UIC)	DESCRIPTION	SERVICE FLAG
00183	NAVHOSP PORTSMOUTH INPT	N
03367	USS JOHN F KENNEDY CV-67	N
03368	USS NIMITZ CVN-68	N
03369	USS EISENHOWER CVN-69	N
04645	USS YELLOWSTONE AD-27	N
04668	USS CHAS F ADAMS DDG-2	N
05106	USS GEO WASH CARVER SSN-598	N
20854	POTOMAC	N
31654	NAVHOSP PORTSMOUTH STAFF	N
57034	COMNAVCONBTLN ATLANTIC	N
68551	PSAD PORTSMOUTH	N

FLYING STATUS CODE	DESCRIPTION	SERVICE FLAG
00	DISQ: ADMIN REASON	F
01	DISQ: FEAR OF FLYING	F
02	DISQ: REASON PENDING	F
03	DISQ: MEDICAL (INDEF)	F
04	DISQ: HUMANITARIAN	F
05	DISQ: FLYING EVAL/OTHER	F
06	DISQ: FLYING/JUMP TERMINATED	F
07	DISQ: DAF MISCELLANEOUS	F
08	DISQ: VOLUNTARY	F
1	DESIGNATED & ON FLYING STATUS	A
1A	ACIP(0-12): ACTIVE/OP FLYING	F
1B	ACIP(0-12): ACTIVE/PROF FLYING	F
1E	ACIP(0-12): ACTIVE/PARACHUTIST	F
1J	ACIP(0-12): INACT/RESTRICTED	F
1K	ACIP(0-12): INACT/NO SUPPORT	F
1L	ACIP(0-12): INACT/SCHOOL	F
1S	ACIP(0-12): INACT/NONPERFORM	F
1U	ACIP(0-12): ACT/FLY TRAINING	F
2	DESIGNATED & NOT ON FLY STATUS	A
2A	ACIP(12-18): ACT/OP FLYING	F
2B	ACIP(12-18): ACT/PROF FLYING	F
2E	ACIP(12-18): ACT/PARACHUTIST	F
2J	ACIP(12-18): INACT/RESTRICTED	F
2K	ACIP(12-18): INACT/NO SUPPORT	F
2L	ACIP(12-18): INACT/SCHOOL	F
2S	ACIP(12-18): INACT/NONPERFORM	F
2U	ACIP(12-18): ACT/STUDENT	F
3A	ACIP(18-25): ACT/OP FLYING	F
3B	ACIP(18-25): ACT/PROF FLYING	F
3E	ACIP(18-25): ACT/PARACHUTIST	F
3J	ACIP(18-25): INACT/RESTRICTED	F
3K	ACIP(18-25): INACT/NO SUPPORT	F
3L	ACIP(18-25): INACT/SCHOOL	F
3S	ACIP(18-25): INACT/NONPERFORM	F
3U	ACIP(18-25): ACT/STUDENT	F
4A	COND(0-12): ACT/OP FLYING	F
4B	COND(0-12): ACT/PROF FLYING	F
4E	COND(0-12): ACT/PARACHUTIST	F
4J	COND(0-12): INACT/RESTRICTED	F
4K	COND(0-12): INACT/NO SUPPORT	F
4L	COND(0-12): INACT/SCHOOL	F
4S	COND(0-12): INACT/NONPERFORM	F
4U	COND(0-12): ACT/STUDENT	F
5A	COND(12-18): ACT/OP FLYING	F
5B	COND(12-18): ACT/PROF FLYING	F
5E	COND(12-18): ACT/PARACHUTIST	F
5J	COND(12-18): INACT/RESTRICTED	F
5K	COND(12-18): INACT/NO SUPPORT	F
5L	COND(12-18): INACT/SCHOOL	F
5S	COND(12-18): INACT/NONPERFORM	F
5U	COND(12-18): ACT/STUDENT	F
6A	COND(18-25): ACT/OP FLYING	F
6B	COND(18-25): ACT/PROF FLYING	F
6E	COND(18-25): ACT/PARACHUTIST	F
6J	COND(18-25): INACT/RESTRICTED	F
6K	COND(18-25): INACT/NO SUPPORT	F

FLYING STATUS CODE	DESCRIPTION	SERVICE FLAG
6L	COND(18-25): INACT/SCHOOL	F
6S	COND(18-25): INACT/NONPERFORM	F
6U	COND(18-25): ACT/STUDENT	F
7A	ACIP TERMINATED: ACT/OP FLYING	F
7B	ACIP TERM: ACT/PROF FLYING	F
7E	ACIP TERM: ACT/PARACHUTIST	F
7J	ACIP TERM: INACT/RESTRICTED	F
7K	ACIP TERM: INACT/NO SUPPORT	F
7L	ACIP TERM: INACT/SCHOOL	F
7S	ACIP TERM: INACT/NONPERFORM	F
7U	ACIP TERM: ACT/STUDENT	F
8F	COND ACIP MED: INACT SEPARATED	F
9C	COND HDIP: ACT/NON-CREW MEMB	F
9D	COND HDIP: ACT/NON-RATED CREW	F
9E	COND HDIP: ACT/PARACHUTIST	F
9G	COND HDIP: ACT/GROUNDED TEMP	F
9J	COND HDIP: INACT/RESTRICTED	F
9L	COND HDIP: INACT/SCHOOL	F
N	NOT APPLICABLE	AN
Y	YES	N

STATE/COUNTRY CODES

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STATE ABBREVIATION	STATE NAME	VALID COUNTRY
AB	ALBANIA	
AC	ANTIGUA	1
AE	ARGENTINA	
AF	AFGHANISTAN	1
AG	ALGERIA	1
AK	ALASKA	
AL	ALABAMA	1
AN	ANDORRA	1
AO	ANGOLA	1
AQ	AMERICAN SAMOA	1
AR	ARKANSAS	1
AS	AUSTRALIA	1
AT	ASHMORE AND CARTIER ISLANDS	1
AU	AUSTRIA	1
AV	ANGUILLA	
AY	ANTARCTICA	1
AZ	ARIZONA	
BA	BAHRAIN	1
BB	BARBADOS	1
BC	BOTSWANA	1
BD	BERMUDA	1
BE	BELGIUM	1
BF	BAHAMA ISLANDS	1
BG	BANGLADESH	
BH	BELIZE	1
BL	BOLIVIA	1
BM	BURMA	1
BP	BRITISH SOLOMON ISLANDS	1
BQ	UNITED STATES MISC. CARRIBEAN ISLANDS	
BR	BRAZIL	1
BT	BHUTAN	1
BU	BULGARIA	1
BV	BOUVET ISLAND	1
BX	BRUNEI	1
BY	BURUNDI	1
BZ	NAVASSA ISLAND	
CA	CALIFORNIA	1
CB	CAMBODIA	1
CC	CANADA	
CD	CHAD	1
CE	SRI LANKA (CEYLON)	1
CF	CONGO (BRAZZAVILLE)	1
CG	ZAIRE, REPUBLIC OF	1
CH	CHINA, PEOPLES REPUBLIC OF	1
CI	CHILE	1
CJ	CAYMAN ISLANDS	1
CK	COCOS ISLAND (INDIAN OCEAN)	1
CL		1
CM	CAMEROON	1
CN	COMORO ISLAND	1
CO	COLORADO	1
CP	CENTRAL AFRICAN REPUBLIC	
CQ	COLUMBIA	
CR	CORAL SEA ISLANDS TERRITORY	
CS	COSTA RICA	1
CT	CONNECTICUTT	1
CU	CUBA	1

STATE ABBREVIATION	STATE NAME	VALID COUNTRY
CV	CAPE VERDE ISLAND	1
CW	COOK ISLAND	1
CY	CYPRUS	1
CZ	CZECHOSLOVAKIA	1
DA	DENMARK	1
DC	DISTRICT OF COLUMBIA	
DE	DELAWARE	
DI	INDONESIA	
DM	DAHOMEY	1
DO	DOMINICA	1
DR	DOMINICAN REPUBLIC	1
EC	EDUADOR	1
EG	EGYPT	1
EI	IRELAND	1
EK	EQUATORIAL GUINEA	1
EQ	CANTON AND ENDERBURY ISLANDS	1
ES	EL SALVADOR	1
ET	ETHIOPIA	1
FA	FALKLAND ISLAND	1
FG	FRENCH GUIANA	1
FI	FINLAND	1
FJ	FIJI	1
FL	FLORIDA	
FO	FAEROES ISLAND	1
FP	FRENCH POLYNESIA	1
FR	FRANCE	1
FS	FRENCH SOUTHERN AND ANTARCTIC LANDS	1
FT	FRENCH TERRITORY OF THE AFARS AND ISSAS	1
GA	GEORGIA	1
GB	GABON	1
GC	GERMANY, EAST	1
GE	GERMANY, FEDERAL REPUBLIC OF	1
GH	GHAÑA	1
GI	GIBRALTAR	1
GJ	GRENADA	1
GL	GREENLAND	1
GM	GAMBIA	
GN	GOLBERT AND ELLICE ISLANDS (INCLUDES CENTRAL AND SOUTHERN LI	
GP	GUADELOUPE	1
GQ	GUAM	1
GR	GREECE	1
GS		1
GT	GUATEMALA	1
GV	GUINEA	1
GY	GUYANA	1
GZ	GAZA STRIP	1
HA	HAITI	1
HI	HAWAII	
HK	HONG KONG	1
HM	HEARD AND MCDONALD ISLANDS	1
HO	HONDURAN (INCLUDES SWAN ISLANDS)	1
HU	HUNGARY	1
IA	IOWA	
IC	ICELAND	1
ID	IDAHO	1
II	INDIA	
IL	ILLINOIS	

STATE ABBREVIATION	STATE NAME	VALID COUNTRY
IN	INDIANA	1
IO	BRITISH INDIAN OCEAN TERRITORY	1
IQ	UNITED STATES MISC. PACIFIC ISLANDS	
IR	IRAN	1
IS	ISRAEL	1
IT	ITALY	1
IU	ISRAEL-SYRIA DEMILITARIZED ZONES	
IV	IVORY COAST	1
IW	ISRAEL-JORDAN DEMILITARIZED ZONES	
IY	IRAQ-SAUDI ARABIA NEUTRAL ZONE	
IZ	IRAQ	1
JA	JAPAN (INCLUDES RYUKYU ISLAND)	1
JM	JAMAICA	1
JN	JAN MAYEN	1
JO	JORDAN	1
JQ	JOHNSTON ATOLL	1
KE	KENYA	1
KN	KOREA, NORTH	1
KR	KOREA, REPUBLIC OF	
KS	KANSAS	1
KT	CHRISTMAS ISLAND (INDIAN OCEAN)	1
KU	KUWAIT	1
KY	KENTUCKY	
LA	LOUISIANA	1
LE	LEBANON	1
LI	LIBERIA	1
LO	LAOS	
LS	LIECHTENSTEIN	1
LT	LESOTHO	1
LU	LUXEMBOURG	1
LY	LIBYA	1
MA	MASSACHUSETTS	1
MB	MARTINIQUE	1
MC	MACAO	1
MD	MARYLAND	
ME	MAINE	1
MF	MALTA	
MG	MONGOLIA	1
MH	MONSERRAT	1
MI	MICHIGAN	1
MJ	MADAGASCAR	
MK	MONACO	
ML	MALI	1
MM	MORROCO	
MN	MINNESOTA	1
MO	MISSOURI	1
MP	MAURITIUS	1
MQ	MIDWAY ISLAND	1
MR	MAURITANIA	1
MS	MISSISSIPPI	
MT	MONTANA	1
MU	OMAN	1
MV	MALDIVES	1
MW	MALAWI	
MX	MEXICO	1
MY	MALAYSIA	1
MZ	MOZAMBIQUE	1

STATE ABBREVIATION	STATE NAME	VALID COUNTRY
NA	NETHERLANDS ANTILLES	1
NC	NORTH CAROLINA	1
ND	NORTH DAKOTA	
NE	NEBRASKA	1
NF	NORFOLK ISLANDS	1
NG	NIGER	1
NH	NEW HAMPSHIRE	1
NI	NIGERIA	1
NJ	NEW JERSEY	
NK	NIUE	
NL	NETHERLANDS	1
NM	NEW MEXICO	
NN	NEW CALEDONIA	
NO	NORWAY	1
NP	NEPAL	1
NR	NAURU	1
NS	SURINAM	1
NU	NICARAGUA	1
NV	NEVADA	
NW	NEW HEBRIDES	
NY	NEW YORK	
NZ	NEW ZEALAND	1
OH	OHIO	
OK	OKLAHOMA	
OR	OREGON	
PA	PENNSYLVANIA	1
PC	PITCAIRN	1
PE	PERU	1
PF	PARACEL ISLANDS	1
PG	SPRATLY ISLANDS	1
PK	PAKISTAN	1
PL	POLAND	1
PN	PANAMA	1
PO	PORTUGAL	1
PP	PAPUA NEW GUINEA	1
PQ	CANAL ZONE	1
PR	PUERTO RICO	
PT	PORTUGESE TIMOR	1
PU	PORTUGESE GUINEA	1
PY	PARAGUAY	
QA	QATAR	1
RE	REUNION	1
RH	SOUTHERN RHODESIA	1
RI	RHODE ISLAND	
RO	ROMANIA	1
RP	PHILIPPINES	1
RQ		1
RW	RWANDA	1
SA	SAUDI ARABIA	1
SB	ST. PIERRE AND MIQUELLON	1
SC	SOUTH CAROLINA	1
SD	SOUTH DAKOTA	
SE	SEYCHELLES	1
SF	SOUTH AFRICA	1
SG	SENEGAL	1
SH	ST. HELENA	1
SI	SPANISH TERRITORY OF NORTHERN MOROCCO	

STATE ABBREVIATION	STATE NAME	VALID COUNTRY
SJ	ST. CHRISTOPHER-NEVIS	
SK	SIKKIM	1
SL	SIERRA LENONE	1
SM	SAN MARINO	1
SN	SINGAPORE	1
SO	SOMALIA	1
SP	SPAIN	1
SQ		1
SS	SPANISH SAHARA	1
ST	ST. LUCIA	1
SU	SUDAN	1
SV	SVALBARDSW	1
SW	SWEDEN	1
SY	SYRIA	1
SZ	SWITZERLAND	1
TC	UNITED ARAB EMIRATES	1
TD	TRINIDAD AND TOBAGO	1
TG	TONGA	
TH	THAILAND	1
TK	TURKS AND CAICOS ISLANDS	1
TL	TOKELAU ISLANDS	1
TN	TENNESSEE	1
TO	TOGO	1
TP	SAO TOME E PRINCIPE	1
TQ	TRUST TERRITORY OF THE PACIFIC ISLANDS	1
TS	TUNISIA	1
TU	TURKEY	1
TV		1
TW	CHINA, REPUBLIC OF	1
TX	TEXAS	
TZ	TANZANIA	1
UG	UGANDA	1
UK	UNITED KINGDOM	1
UR	SOVIET UNION	1
US	UNITED STATES	
UT	UTAH	
UV	UPPER VOLTA	1
UY	URUGUAY	1
VA	VIRGINIA	
VC	ST. VINCENT	1
VE	VENEZUELA	1
VI	VIRGIN ISLANDS	1
VK	VIRGIN ISLANDS (U.S.)	
VN		1
VQ		1
VS		1
VT	VERMONT	1
WA	WASHINGTON	1
WB		1
WF		1
WI	WISCONSIN	
WQ		1
WS		1
WV	WEST VIRGINIA	
WY	WYOMING	
WZ		1
YE		1

1

STATE/COUNTRY CODES AUG 31,1985 19:18 PAGE 6

STATE ABBREVIATION	STATE NAME	VALID COUNTRY
YO		1
YQ		1
YS		1
ZA		1

COMMAND INTEREST CODE	DESCRIPTION
COM	NOTIFY COMMANDER
CON	CONGRESSIONAL
COP	NOTIFY OUTPATIENT SERVICES CHIEF
ENV	CALL ENVIRONMENTAL HEALTH
FLA	FLAG ADMISSION
FOR	FOREIGN DIGNITARY
LEG	CALL LEGAL OFFICER
LOD	POTENTIAL LINE OF DUTY INJURY
PAY	PAY PATIENT
PDP	POTENTIAL DANGEROUS PERSON
PRP	PERSONNEL RELIABILITY PROGRAM
PTA	CALL PATIENT AFFAIRS
STF	STAFF MEMBER
TPL	POTENTIAL THIRD PARTY LIABILITY
VIP	VIP

MAJCR COMMAND CODE	DESCRIPTION
AAC	ALASKAN AIR COMMAND
AAG	AIR FORCE AUDIT AGENCY
AAO	AIR FORCE AUDIT AGENCY (OVERSEAS)
AAZ	ALASKAN AIR COMMAND (Z/I)
ACC	AERONAUTICAL CHART AND INFORMATION CENTER (HISTORICAL)
ADC	AEROSPACE DEFENSE COMMAND
ADO	AEROSPACE DEFENSE COMMAND (OVERSEAS)
AFA	US AIR FORCE ACADEMY
AFC	AIR FORCE ACCOUNTING AND FINANCE CENTER
AFE	US AIR FORCE IN EUROPE
AFO	HQ AIR FORCE RESERVE (OVERSEAS)
AFR	HQ AIR FORCE RESERVE
AFZ	US AIR FORCE IN EUROPE (Z/I)
ANC	AIR FORCE INTELLIGENCE CENTER
ASG	1947 ADMIN SUPP GROUP HQ, ALBERT F. SIMPSON HIST RESEARCH CENTER
ATC	AIR TRAINING COMMAND
ATO	AIR TRAINING COMMAND (OVERSEAS)
AUM	AIR UNIVERSITY (HISTORICAL)
AUO	AIR UNIVERSITY (OVERSEAS)(HISTORICAL)
CBT	AIR FORCE COMBAT OPERATIONS STAFF
CMC	AIR FORCE COMMUNICATIONS SERVICE
CMO	AF COMMUNICATIONS COMMAND (OVERSEAS)
CMS	AIR FORCE COMMISARY SERVICE
CSO	AIRFORCE COMMUNICATIONS SERVICE (OVERSEAS)
DAA	AIR FORCE DATA AUTOMATION AGENCY (HISTORICAL)
DAO	AIR FORCE DATA AUTOMATION AGENCY (OVERSEAS) (HISTORICAL)
ELC	ELECTRONIC SECURITY COMMAND
ELM	ASSGN CONUS AND ALL OTHER AREAS NEC
ESA	AIR FORCE ENGINEERING AND SERVICES AGENCY (HISTORICAL)
ESC	AIR FORCE ENGINEERING & SERVICES CENTER
EUR	ASSGN IN AREAS SERVED BY USAFE AND NEC
F12	NAT GUARD OR RESERVE ACTIVE DUTY FOR TRAINING
F21	NAT GUARD OR RESERVE INACTIVE DUTY FOR TRAINING
HAF	HEADQUARTERS USAF
HAO	HEADQUARTERS USAF (OVERSEAS)
HQC	HEADQUARTERS COMMAND, USAF (SEE NOTE 1) (HISTORICAL)
HQO	HEADQUARTERS COMMAND, USAF (OVERSEAS) (SEE NOTE 1) (HISTORICAL)
HRS	USAF HISTORICAL RESEARCH CTR
ICT	AIR FORCE SERVICE INFORMATION & NEWS CENTER
IGC	AIR FORCE INSPECTOR GENERAL ACTIVITIES CENTER
INO	AIR FORCE INTELLIGENCE SERVICE (OVERSEAS) (HISTORICAL)
INT	AIR FORCE INTELLIGENCE SERVICE (HISTORICAL)
ISC	AIR FORCE INSPECTION AND SAFETY CENTER (HISTORICAL)
ISO	AIR FORCE INSPECTION AND SAFETY CENTER (OVERSEAS) (HISTORICAL)
KDA	AIR FORCE COMMUNICATIONS SERVICE (OLD)
LCT	AIR FORCE LEGAL SERVICES CENTER
LOG	AIR FORCE LOGISTICS COMMAND
LOO	AIR FORCE LOGISTIC COMMAND (OVERSEAS)
MAC	MILITARY AIRLIFT COMMAND
MAO	MILITARY AIRLIFT COMMAND (OVERSEAS)
MCT	AF MEDICAL SERVICE CENTER
MEA	AIR FORCE MANAGEMENT ENGINEERING AGENCY (HISTORICAL)
MPC	AIR FORCE MANPOWER & PERSONNEL CENTER
NGS	HEADQUARTERS, AIR NATIONAL GUARD SUPPORT CENTER
OAR	OFFICE OF AEROSPACE RESEARCH (HISTORICAL)
OMS	OFFICE OF MEDICAL SUPPORT

MAJOR COMMAND CODE	DESCRIPTION
OSI	AIR FORCE OFFICE OF SPECIAL INVESTIGATION (HISTORICAL)
OSO	AIR FORCE OFFICE OF SPECIAL INVESTIGATION (OVERSEAS) (HISTORICAL)
OSP	AF OFFICE OF SECURITY POLICE
PAF	PACIFIC AIR FORCE
PAZ	PACIFIC AIR FORCE (Z/I)
RPC	AIR RESERVE PERSONNEL CENTER (HISTORICAL)
SAC	STRATEGIC AIR COMMAND
SAO	STRATEGIC AIR COMMAND (OVERSEAS)
SCO	SPACE COMMAND OPERATIONS
SOZ	USAF SOUTHERN COMMAND (Z/I) (HISTORICAL)
SPC	SPACE COMMAND
SPO	SPACE COMMAND (OVERSEAS)
SUO	USAF SOUTHERN COMMAND (HISTORICAL)
SYO	AIR FORCE SYSTEMS COMMAND (OVERSEAS)
SYS	AIR FORCE SYSTEM COMMAND
TAC	TACTICAL AIR COMMAND
TAO	TACTICAL AIR COMMAND (OVERSEAS)
TEC	AIR FORCE TEST AND EVALUATION CENTER
USO	USAF SECURITY SERVICE (OVERSEAS) (HISTORICAL)
USS	USAF SECURITY SERVICE (HISTORICAL)
ZXZ	BAD CODE
ZZZ	MAJOR COMMAND UNKNOWN

TERM CAPABILITIES

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TERM NBR	CAPABILITIES	LOCKOUT FLAG	DEFAULT PRINTER NUMBER
1			
3	D		1
4	RADTHB1CSPEI2Q		1
7	RADTHB		
11			
14			
17			
44			
44			
53	RADTHPQCSEBI12	0	72
64	RADTBHS19PIQCE2	0	72
65	RADTBCHS19PIEQ2		1
66	RADTBCHS19PIQE2		1
67	RADTBCHS19PQE2I	0	1
68	RADTH1PQCSEBI	0	1
69	ADTIHCPSB1RQE	0	1
70	ATI2CBHIEQPS1RD		72
71	ATISCPHBQE1RD2	0	72
72			
73	RADTBCHS19PIQE	0	1
74	RADTIHBSECQP12		1
75	RADT1HIC2BESQP	0	1
76	RADT1HIC2BESQP	0	1
77	RADTHICPSQEB	0	1
78	RADTH1PQCSEBI2		1
79	RADTIHBSECQP12	0	1
80	RADTBHS19PIQCE	0	1
81	RADTBHS19PIQCE	0	1
81	RADTH1PQCSEBI	0	1
82	RADTBCHS1PIQE		1
83	RADTBCHS19PIEQ2	0	1
85	ADTIHCPSB1RQE		1
87	ATISCPHBQE1RD2	0	1
89	S		

FUNCTION TABLE AUG 31,1985 19:50 PAGE 1

FUNCTION	DESCRIPTION	MENU PROMPT	FUNCTION TIMEOUT	PROGRAM
1	R/ADT REPORTS	1 - R/ADT REPORTS	60	RPR
2	CR REPORTS	2 - CLINICAL RECORDS REPORTS	60	RPR
A	ADMISSION	A - ADMISSION PROCESSING	999	PT PTLCK NDATE AT
B	BED MANAGEMENT	B - BED MANAGEMENT PROCESSING	600	NDATE BM
C	CLINICAL RECORDS	C - CLINICAL RECORDS PROCESSING	600	NDATE CR
D	DISPOSITION	D - DISPOSITION PROCESSING	999	PT PTLCK NDATE DS
E	CORRECTION MGMT	E - CORRECTION MANAGEMENT	300	NDATE CM
H	HISTORY	H - INPATIENT HISTORY	300	PT EP NDATE HS
I	PATIENT INQUIRY	I - PATIENT INQUIRY	300	NDATE PI
M	MED ACCT	M - MEDICAL ACCOUNTING		
O	BUSINESS OFF.	O - BUSINESS OFFICE		
P	PROFILING	P - PROFILING	180	NDATE CP
Q	QUALITY ASSURANCE	Q - QUALITY ASSURANCE	180	NDATE QA
R	REGISTRATION	R - REGISTRATION PROCESSING	999	PT PTLCK NDATE RG
S	SYSTEM MGMT	S - SYSTEM MANAGEMENT	180	NDATE SY
T	TRANSFER	T - TRANSFER PROCESSING	999	PT PTLCK NDATE AT

PRODUCT DEVICE

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PROGRAM NAME	DEVICE IDX	DEVICE PRIORITY	DEVICE NUMBER
A&D1	1	1	72
ATCOVER	1	1	72
ATCRD	1	1	72
ATNIR	1	1	72
CONSOLE	1	1	72
CR1	1	1	72
CRCES	1	1	72
CRDFT	1	1	72
CRFIN	1	1	72
	1	1	1
	2	2	72
QA1	1	1	72
RGFORM	1	1	72
SYTLS	1	1	72

BRANCH OF SERVICE	DESCRIPTION	FLAG	SERVICE FLAGS
A	ARMY	1	AFN
F	AIR FORCE	1	AFN
M	MARINE CORPS	1	AFN
N	NAVY	1	AFN
O	NOAA	1	AFN
P	USCG COAST GUARD	1	AFN
U	UNKNOWN	1	FN
W	PHS(PUBLIC HEALTH SVC)	1	AFN
X	CIVILIAN	1	FN

BRANCH OF SERVICE

SEP 4,1985 14:35 PAGE 1

BRANCH OF SERVICE	DESCRIPTION	FLAG	SERVICE FLAGS
A	ARMY	1	AFN
AD	AIR DEFENSE ARTILLERY	2	A
AG	ADJ GENERAL	2	A
AN	ARMY NURSE CORP	2	A
AR	ARMOR	2	A
CH	CHAPLAIN	2	A
CM	CHEMICAL CORP	2	A
DE	DENTAL CORP	2	A
EN	ENGINEER CORP	2	A
F	AIR FORCE	1	AFN
FA	FIELD ARTILLERY	2	A
FI	FINANCE CORP	2	A
FN	UNKNOWN	2	A
GO	GENERAL OFFICER	2	A
IG	INSPECTOR GENERAL	2	A
IN	INFANTRY	2	A
JA	JUDGE ADVOCATE GEN CORP	2	A
M	MARINE CORPS	1	AFN
MC	MEDICAL CORP	2	A
MI	MILITARY INTELLIGENCE	2	A
MP	MILITARY POLICE	2	A
MS	MEDICAL SERVICE	2	A
N	NAVY	1	AFN
O	NOAA	1	AFN
OR	ORDNANCE CORP	2	A
P	USCG COAST GUARD	1	AFN
PR	PROFESSOR USMA	2	A
QM	QUARTERMASTER CORP	2	A
SC	SIGNAL CORP	2	A
SP	MED SPECIALITY CORP	2	A
TC	TRANSPORTATION CORP	2	A
VC	VETERINARY CORP	2	A
W	PHS(PUBLIC HEALTH SVC)	1	AFN

RACE CODE LIST

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RACE CODE	DESCRIPTION	SERVICE FLAG
1	AMER INDIAN/ALSK NATIVE(AAN)	A
2	ASIAN/PAC ISLANDER(API)	A
3	BLACK OF NON-HISP ORIG(BNH)	A
4	BLACK OF HISP ORIGIN(BHO)	A
5	WHITE NOT OF HISP ORIG(WNH)	A
6	WHITE OF HISP ORIGIN(WHO)	A
7	UNKNOWN	A
C	CAUCASIAN	FN
G	MONGOLIAN	N
I	INDIAN	N
M	MALAYAN	N
N	NEGROID	FN
U	UNKNOWN	N
X	OTHER	F
Z	UNKNOWN	F

ZIP CODE	CITY,STATE
20064	WASHINGTON,DC
20067	WASHINGTON,DC
20068	WASHINGTON,DC
20070	WASHINGTON,DC
20071	WASHINGTON,DC
20073	WASHINGTON,DC
20074	WASHINGTON,DC
20075	WASHINGTON,DC
20076	WASHINGTON,DC
20080	WASHINGTON,DC
20081	WASHINGTON,DC
20082	WASHINGTON,DC
20084	WASHINGTON,DC
20088	WASHINGTON,DC
20097	WASHINGTON,DC
20098	WASHINGTON,DC
20201	WASHINGTON,DC
20202	WASHINGTON,DC
20203	WASHINGTON,DC
20204	WASHINGTON,DC
20205	WASHINGTON,DC
20206	WASHINGTON,DC
20207	WASHINGTON,DC
20210	WASHINGTON,DC
20211	WASHINGTON,DC
20212	WASHINGTON,DC
20213	WASHINGTON,DC
20214	WASHINGTON,DC
20215	WASHINGTON,DC
20216	WASHINGTON,DC
20217	WASHINGTON,DC
20220	WASHINGTON,DC
20221	WASHINGTON,DC
20222	WASHINGTON,DC
20223	WASHINGTON,DC
20224	WASHINGTON,DC
20225	WASHINGTON,DC
20226	WASHINGTON,DC
20227	WASHINGTON,DC
20228	WASHINGTON,DC
20229	WASHINGTON,DC
20230	WASHINGTON,DC
20231	WASHINGTON,DC
20233	WASHINGTON,DC
20234	WASHINGTON,DC
20235	WASHINGTON,DC
20240	WASHINGTON,DC
20241	WASHINGTON,DC
20242	WASHINGTON,DC
20244	WASHINGTON,DC
20245	WASHINGTON,DC
20250	WASHINGTON,DC
20251	WASHINGTON,DC
20252	WASHINGTON,DC
20260	WASHINGTON,DC
20261	WASHINGTON,DC
20265	WASHINGTON,DC
20268	WASHINGTON,DC

CAPABILITY PROFILES SEP 4,1985 14:36 PAGE 1

PROFILE NAME	DESCRIPTION	CAPABILITY STRING
'A&D SUP'	A&D SUPERVISOR	RADTICHBE1
'A&D'	A&D CLERK	RADTIH1B
'BED'	BED MANAGEMENT	B
'BEDS'	BED CLERK	BI1
'CR SUP'	CR SUPERVISOR	CEI2H1
'CR'	CR CLERK	C2IH
'INFO'	INFORMATION ONL\	I1
'PAD'	PATIENT ADMIN	RADTICHBE12
'QA COOR'	QA COORDINATOR	QPI12
'QA'	QA ASST	QI12
'REGS'	REGISTRATION CLERK	RI
'SM'	SYSTEM MANAGER	RADTH1PQCSEBI2
'TRANS'	TRANFER CLERK	TI1

MILITARY SPECIALTY LIST AUG 21,1985 06:58 PAGE 1

NAME	DESCRIPTION	SERVICE FLAGS
0001	PATIENT	F
0002	GENERAL OFFICER	F
0003	STUDENT OFFICER AUTHORIZATION	F
0004	UNALLOTED	F
0005	NUCLEAR WEAPONS CUSTODIAN	F
0006	PILOT, TRAINEE	F
0007	NAVIGATOR TRAINEE	F
0008	UNCLASSIFIED OFFICER	F
0016	DIRECTOR OF PERSONNEL MGMT	F
0026	ORGANIZATION COMMANDER	F
0036	DIRECTOR OF OPERATIONS	F
0046	DIRECTOR OF LOGISTICS	F
0056	COMPTROLLER	F
0066	AIR COMMANDER	F
0076	PLANNING/PROGRAMMING OFFICER	F
0086	MISSLE COMMANDER	F
0096	DIRECTOR OF RESOURCE MGMT	F
00A	OFFICER, DUTIES UNASSIGNED	A
00B	DIVER/GENERAL OFFICER	A
00C	OFFICER, NO DUTY, SIQ, HOSP	A
00D	SPECIAL DUTY ASSIGNMENT/ROTC OFF AWAIT ACDU/ADT	A
00E	STUDENT OFFICER OR RECRUITER	A
00F	USMA PROFESSOR	A
00J	CLUB MANAGER	A
00U	EQUAL OPPORTUNITY NCO	A
00Z	COMMAND SERGAENT MAJOR	A
01	USMC PERS/ADM	N
0106	USUHS STUDENT	F
0107	HPSP MEDICAL STUDENT	F
0108	HPSP DENTAL STUDENT	F
0109	HPSP VETERINARY STUDENT	F
0110	EXCESS LEAVE LAW STUDENT	F
0111	FUNDED LEGAL ED PROG LAW STUD	F
0112	NONDESIGNATED LAWYER	F
0113	HPSP BIOMED SCIENCE STUDENT	F
0114	AFROTC DELAY LAW STUDENT	F
0115	CHAPLAIN CANDIDATE	F
0116	CIVIL AIR PATROL LIASON	F
01H	BIOLOGICAL SCIENCES ASSISTANT	A
02	USMC INTELLIGENCE	N
0216	INTERNAT POLIT-MIL AFFAIRS OFF	F
02B	CORONET/TRUMPET PLAYER	A
02C	BARITONE/EUPHONIUM PLAYER	A
02D	FRENCH HORN PLAYER	A
02E	TROMBONE PLAYER	A
02F	TUBA PLAYER	A
02G	FLUTE/PICCOLO PLAYER	A
02H	OBOE PLAYER	A
02J	CLARINET PLAYER	A
02K	BASSOON PLAYER	A
02L	SAXAPHONE PLAYER	A
02M	PERCUSSION PLAYER	A
02N	PIANO PLAYER	A
02P	BRASS GROUP LEADER	A
02Q	WOODWIND GP LEDER	A
02R	PERCUSSION GROUP LEADER	A
02S	SPECIAL BNDPERSON	A

NAME	DESCRIPTION	SERVICE FLAGS
02T	GUITAR PLAYER	A
02Z	ENLISTED BANDLEADER	A
03	USMC INFANTRY	N
03C	PHYSICAL ACTIVITY SPEC	A
04	USMC LOGISTICS	N
0516	DISASTER PREP STAFF OFFICER	F
0524	BASE DISASTER PREP OFFICER	F
05B	RADIO OPERATOR	A
05C	RADIO TELETYPE OPERATOR	A
05D	EW/SIGINT EMITTER ID/LOC	A
05G	SIGNAL SECURITY SPEC	A
05H	EW/SIGINT MORSE INTERCEPTOR	A
05K	EW/SIGINT N/MORSE INTERCEPTOR	A
08	USMC FIELD ARTILLERY	N
0900	COMMANDER, CADET SQ, USAF ACAD	F
0910	AIR ATTACHE	F
0920	RECRUITING SERVICE OFFICER	F
0930	HISTORICAL OFFICER	F
0940	INSTRUCTOR	F
0950	TRAINING COMMANDER, OTS	F
09C	COLLEGE TRAINEE	A
09S	COMM OFF CANDIDATE	A
09T	RESERVE FORCE RC	A
09W	WARRENT OFFICER CANDIDATE	A
100	FIRST SERGAENT	F
1025	PILOT, HELICOPTER	F
1035	PILOT, SEARCH-RESCUE	F
1045	PILOT, TRANSPORT	F
1055	PILOT, TACTICAL AIRLIFT	F
1065	PILOT, TANKER	F
11	NAVY LINE OFFICER SUR,SUB,SPEC/USMC WEATHER SERVICE	N
111	DEFENSIVE AERIAL GUNNER	F
1115	PILOT, FIGHTER	F
112	IN-FLIGHT REFUELING OPER	F
113	FLIGHT ENGINEER TECH	F
114	AIRCRAFT LOADMASTER	F
1145	PILOT, FORWARD AIR CONTROLLER	F
115	PARARESCUE TECH	F
116	AIRBORNE COMM SYS OPER	F
1165	PILOT, MISSION SUPPORT	F
11A	INFANTRY OFFICER, GENERAL	A
11B	INFANTRYMAN/LIGHT INFANTRY OFF	A
11C	INDIRECT FIRE INFANTRYMAN/MECH INFANTRY OFFICER	A
11H	HEAVY ANTI-ARMOR WEAP CREW MBR	A
11M	FIGHTING VEHICLE INFANTRY	A
121	SURVIVAL TRAINING TECH	F
122	AIRCREW LIFE/SUPP SPEC	F
1235	PILOT, STRATEGIC BOMBER	F
12A	ARMOR OFFICER, GENERAL	A
12B	COMBAT ENGINEER/ARMOR UNIT OFFICER	A
12C	BRIDGE CREWMAN/CALVARY UNIT OFFICER	A
12E	ATOMIC DEMO MUNITION SPEC	A
12F	ENG TRACKED VEHICLE CREWMAN	A
12Z	COMBAT ENGINERRING SENIOR SGT	A
13	NAVY LINE OFFICER AVIATION/USMC CONSTRUCTION EQUIP	N
1315	PILOT, SPECIAL OPS	F
1325	PILOT, SPECIAL RECON	F

NAME	DESCRIPTION	SERVICE FLAGS
1335	PILOT, STRATEGIC RECON	F
1345	PILOT, TACTICAL RECON	F
1355	PILOT, FLT TRAINING INST	F
13A	FIELD ARTILLERY OFF, GEN	A
13B	CANNON CREWMAN/LIGHT MSL FLD ART OFFICER	A
13C	TACFIRE OPS SPEC/HEAVY MSL FLD ART OFFICER	A
13D	FLD ART TARGET ACQUIS OFF	A
13E	CANNON FIRE DIRECTION SPEC/CANNON FLD ART OFFICER	A
13F	FIRE SUPPORT SPEC	A
13R	FLD ARTILLERY FIREFINDER	A
13W	FLD ART ACQUISITION SENIOR SGT	A
13Y	CANNON/MISSLE SENIOR SGT	A
13Z	FLD ARTILLERY SENOIR SGT	A
14	NAVY LINE OFFICER ENGINEERING/USMC DRAFTING,SURVEY,MAPPING	N
1406	AIR OPS STAFF DIRECTOR PIL	F
1415	AIR OPS PIL(RECON)	F
1425	AIR OPS PIL(TRANS/AIRLIFT)	F
1435	AIR OPS PIL(STRAT BOMB/TANK)	F
1455	AIR OPS PIL(FIGHTER)	F
1475	AIR OPS PIL(SPEC RECON)	F
1485	AIR OPS HELI PIL(SRCH/RSCU)	F
1495	AIR OPS PIL(OTHER)	F
14A	AIR DEF ART, GENERAL	A
14B	SHORAD OFFICER	A
14C	NIKE/HERC MSL AIR DEF OFF	A
14D	HAWK MSL AIR DEF OFF	A
14E	PATRIOT AIR DEF OFF	A
14G	AIR DEF ART CMND/CNTL OFF	A
15	NAVY LINE OFFICER AERO ENG/USMC PRINTING AND PUBS	N
1505	NAVIGATOR, STRAT RECON	F
1515	NAVIGATOR, TACT RECON	F
1525	NAVIGATOR-BOMBARDIER, STRAT	F
1535	NAVIGATOR, TANKER	F
1545	NAVIGATOR, AIRLIFT/TRANS	F
1555	NAVIGATOR,WEAP SYS,FIGHTER	F
1565	NAVIGATOR, SPECIAL RECON	F
1575	NAVIGATOR, ELEC WARFARE OFF	F
1585	NAVIGATOR, SPECIAL OPS	F
1595	NAVIGATOR, FLT TRAINING INST	F
15A	GENERAL AVIATION OFFICER	A
15B	COMBAT AVIATION OFFICER	A
15C	CMBT SUPPORT AVIATION	A
15D	LANCE MISSILE CREW MEMBER	A
15E	PERSHING MSL CREWMBR	A
15J	LANCE OPS/FIRE DIR SPEC	A
15M	CMBT INTEL AVIATION	A
15S	CMBT COMM AVIATION	A
16	NAVY LINE OFFICER SPECIAL DUTY	N
1616	AIR TRAFFIC CONTRAL STAFF OFF	F
1634	AIR TRAFFIC CONTROL OPS	F
16B	HERCULES MISSLE CREW MEMBER	A
16C	HERCULES FIRE CONT CREW MBR	A
16D	HAWK MISSLE CREW MEMBER	A
16E	HAWK FIRE CONT CREW MEMBER	A
16F	LIGHT AIR DEF ART CREW(RES)	A
16H	ADA OPERATIONS/INTLL ASSITANT	A
16J	DEFENSE ACQUISITION RADAR OPER	A

NAME	DESCRIPTION	SERVICE FLAGS
16F	ADA SHORT RNG MISSLE CREWMAN	A
16K	ADA SHORT RNG GUNNERY CREWMAN	A
16S	MANPADS CREWMAN	A
16T	PATRIOT MSL CREWMBR	A
16Z	AIR DEF ART SENIOR SERGAENT	A
17	NAVY LINE OFFICER ORD ENG	N
1716	AIR WEAPONS DIRECTOR STAFF OFF	F
1744	AIR WEAPONS CONTROLLER	F
17B	FLD ART RADAR CREW MEMBER	A
17C	FLD ART ACQUISITION SPEC	A
17K	GND SURV RADAR CREW MEMBER	A
17L	AERIAL SENSOR SPEC(RES)	A
17M	UNATTENDED GND SENSOR SPEC	A
18	NAVY LINE OFFICER SPEC DUTY/USMC TRAINING,AUDIOVISUAL SUPP	N
1816	MISSLE OPS STAFF OFFICER	F
1825	MISSLE LAUNCH OFFICER	F
1835	MISSLE OPS OFFICER	F
1896	MISSLE OPS DIRECTOR	F
18A	SPEC OPS GENERAL	A
19	NAVY LINE OFFICER PROS STAFF	N
19D	CAVALRY SCOUT	A
19E	M48-M60A1/A3 ARMOR CREWMAN	A
19F	M48/M60 TANK DRIVER	A
19G	ARMOR RECON VEHICLE CREWMAN	A
19H	ARMOR RECON VEHICLE DRIVER	A
19J	M60A2 ARMOR CREWMAN	A
19K	XM1 ARMOR CREWMAN	A
19L	XM1 TNK DRIVER	A
19Z	ARMOR SENIOR SERGAENT	A
201	INTELLIGENGE OP/TARGETING TECH	F
2016	SPACE OPS STAFF OFFICER	F
202	RADIO COMM ANALYSIS TECH	F
2025	SPACE OPS ANALYST	F
203	LINGUIST/INTERROGATOR TECH	F
2035	SPACE OPS OFFICER	F
2045	MANNED SPACE FLT OPS OFF.	F
205	ELEC INTELLIGENCE OPS TECH	F
2055	SATELLITE OPS OFFICER	F
206	IMAGERY INTERPRTER TECH	F
2066	ASTRONAUT	F
207	COMM COLLECT/SYS TECH	F
208	CRYPTO LINGUIST SPEC	F
209	DEFENSIVE C3CM SPEC	F
2096	SPACE OPS DIRECTOR	F
21	NAVY MEDICAL CORPS OFFICER/USMC ORDINANCE	N
21G	PERSHING ELEC MAT SPEC	A
21J	COMBAT ENGINEER	A
21K	ENGINEER OFF, GENERAL	A
21L	PERSHING ELEC REPAIRER	A
22	NAVY DENTAL CORPS	N
2206	AIR OPS STAFF DIRECTOR NAV	F
2215	AIR OPS NAV(RECON)	F
222	GEODETIC TECH	F
2225	AIR OPS NAV(STRAT BOMB/TANK)	F
2245	AIR OPS NAV(TRANS/AIRLIFT)	F
2255	AIR OPS NAV(FIGHTER)	F
2265	AIR OPS NAV(SPECIAL RECON)	F

NAME	DESCRIPTION	SERVICE FLAGS
2285	AIR OPS NAV(SPECIAL OPS)	F
2295	AIR OPS NAV(OTHER)	F
22A	TOPOGRAPHIC ENGINEER	A
22L	NIKE TEST EQUIP REPAIRER	A
22N	NIKE HERC MISSLE-LAUNCHER REP	A
23	NAVY MEDICAL SERVICE CORPS OFF/USMC AMMO-EXPL ORD DISP	N
231	AUDIOVISUAL MEDIA SPEC	F
2316	AUDIOVISUAL STAFF OFFICER	F
232	AUDIOVISUAL PROD/DOC SPEC	F
2324	AUDIOVISUAL OFFICER	F
233	CONT PHOTOPROCESS SPEC	F
23A	FAC MNGMT ENGINEER	A
23B	CONTRACT CONST MNGMT ENG	A
23N	NIKE TRACK RADAR REPAIRER	A
23U	NIKE RADAR SIMULATOR REP	A
23W	NIKE MAINTENANCE CHIEF	A
241	SAFETY TECH	F
242	DISASTER PREPAREDNESS SPEC	F
24C	IMP HAWK FIRING SEC MECH	A
24E	IMP HAWK FIRE CONT MECH	A
24G	IMP HAWK INFO COOD CEN MECH	A
24H	IMP HAWK FIRE CONT REPAIRER	A
24J	IMP HAWK PULSE RADAR REPAIRER	A
24K	IMP HAWK CONT WAVE RADAR REP	A
24L	IMP HAWK LAUNCH/MECH SYS REP	A
24M	VULCN SYSTEM MECHANIC	A
24N	CHAPARRAL SYS MECHANIC	A
24P	DEFENSE ACQUISITION RADAR MECH	A
24Q	NIKE HERCULES FIRE CONT MECH	A
24R	IMP HAWK MASTER MECH	A
24T	PATRIOT SYSTEM MECH	A
24U	HERCULES ELEC MECH	A
24V	IMP HAWK MAINT CHIEF	A
25	NAVY JAG CORPS OFFICER/USMC OPERATIONAL COMM	N
251	WEATHER TECH	F
2516	WEATHER STAFF OFFICER	F
2524	WEATHER OFFICER	F
2534	AERIAL RECON WEATHER OFFICER	F
2546	ADVANCED WEATHER OFFICER	F
2585	SCIENTIFIC ANALYST	F
25A	COMMUNICATIONS-ELECTRONICS	A
25B	TELEPROCESSING OPS	A
25J	OPERATIONS CENTRAL REPAIRER	A
25L	AN/TSQ-73 OPERATOR/REPAIRER	A
25Z	FIRE DIST SYS MAINT CHEIF	A
26	USMC SIG INT/GRND ELEC WARFARE	N
2616	SCIENTIFIC MANAGER	F
2625	COMPUTER RESEARCH SCIENTIST	F
2635	PHYSICIST	F
2645	CHEMICAL RESEARCH OFFICER	F
2655	METALLURGIST	F
2665	NUCLEAR RESEARCH OFFICER	F
2675	BEHAVIORAL SCIENTIST	F
26C	COMAT AREA SURV RADAR REP	A
26D	GND CONT APPROACH RADAR REP	A
26E	AERIAL SURV SENSOR REPAIR	A
26H	AIR DEFENSE RADAR REPAIRER	A

NAME	DESCRIPTION	SERVICE FLAGS
26K	AERIAL WARN DEF EQIP REPAIR	A
26L	TAC MICROWV SYS REPAIRER	A
26M	AERIAL SURV RADAR REP(RES)	A
26N	AERIAL SURV INFARED REP(RES)	A
26Q	TAC SAT MICROWV SYS OPERATOR	A
26R	STRAT SAT MICROWV SYS OPERAT	A
26T	RADIO/TV SYS SPEC	A
26V	STRAT MICROWAVE SYS REPAIRER	A
26Y	SATCOMM GND STA EQUIP REP	A
271	AIRFEILD MANAGMENT SPEC	F
2716	AQUISITION MGMT OFFICER	F
272	AIR TRAFFIC CONT OPER	F
2724	AQUISITION PROJECT OFFICER	F
273	COMBAT CONTROL OPERATOR	F
2736	COMP SYS AQUISITION MANAGER	F
274	COMMAND/CONTROL SPEC	F
275	TAC AIR CMD/CONTROL TECH	F
276	AEROSPACE CONT/WARN SYS OPER	F
277	SPACE SYS OPERATIONS TECH	F
27A	COMM-ELEC ENGINEER OFF	A
27B	COMM-ELEC SYSTEMS ENG	A
27E	TOW/DRAGON REPAIRER	A
27F	VULCAN REPAIRER	A
27G	CHAPARRAL/RED EYE REPAIRER	A
27H	SHILLELAGH REPAIRER	A
27Z	BAL/LND COM/LT AIR DEF SYS MNT	A
28	USMC DATA/COMM MAINTENANCE	N
2816	STAFF DEVELOPMENT ENG MNGR	F
2825	ELECTRONIC ENGINEER	F
2835	MECHANICAL ENGINEER	F
2845	ASTRONAUTICAL ENGINEER	F
2855	AERONAUTICAL ENGINEER	F
2865	EXPERIMENTAL TEST PILOT	F
2875	EXPERIMENTAL TEST NAVIGATOR	F
2885	COMPUTER SYS ENGINEER	F
2895	PROJECT ENGINEER	F
29	NAVY NURSE CORPS OFFICER	N
293	GROUND RADIO OPERATOR	F
296	COMM RESOURCE MGMT TECH	F
297	RADIO FREQUENCY MGMT TECH	F
2996	PROGRAM MANGER	F
30	USMC SUPPLY ADM/OPS	N
302	AIRBN METR/ATMOS RESRCH EQ SP	F
303	AIR CONT/WARN RADAR SPEC	F
304	GRND RADIO COMM TECH	F
305	COMPUTER/SWITCHING MAINT TECH	F
306	ELEC COMM/CRYPTO SYS TECH	F
307	TELECOMM SYS CONTROL TECH	F
309	SPACE SYS MAINT TECH	F
31	NAVY SUPPLY CORPS OFFICER/USMC UTILITIES	N
3116	MISSLE MAINT STAFF OFF	F
3124	MISSLE MAINT OFFICER	F
316	INSTUMENTATION TECH	F
3196	MISSLE MAINT DIRECTOR	F
31A	LAW ENFORCEMENT OFF	A
31B	CORRECTIONAL OFF	A
31C	CRIMINAL INVEST OFF	A

NAME	DESCRIPTION	SERVICE FLAGS
31D	PHYSICAL SECURITY OFF	A
31E	FIELD RADIO REPAIRER	A
31J	TELETYPEWRITER REPAIRER	A
31M	MULTI-CHAN COMM EQUIP OPER	A
31N	TACTICL CIRCUIT CONTROLLER	A
31S	FIELD GEN COMSEC REPAIRER	A
31T	FIELD SYS COMSEC REPAIRER	A
31V	TAC COMM SYS OPERATOR MECH	A
31Z	COMM-ELEC OPERATIONS CHEIF	A
321	AVIONIC WEAPON DEL SYS SPEC	F
322	AVIONIC SENSOR SYS SPEC	F
323	AVIONICS SYS SPEC	F
324	PRECISION MEASURMENT LAB TECH	F
325	AUTO FLT CONT/AVIONIC SYS SPEC	F
326	AVIONIC GRND EQUIP SPEC	F
328	COMM/NAV SYS EQUIP SP	F
32D	STATION TECH CONTROLLER	A
32F	FIXED CIPHONY REPAIRER	A
32G	FIXED CRYPTOGRAPH EQUIP REP	A
32H	FIXED STAT RADIO REPAIRER	A
32Z	COMM-ELEC MAINT CHEIF	A
33	USMC FOOD SERVICE	N
33S	EW/INTERCEPT SYS REPAIRER	A
34	*USMC AUDIT, FINANCE/ACCT*	N
341	DEFENSIVE SYS TRAINER	F
34B	PUNCHCARD MACH REPAIRER	A
34C	DECENT AUTO SVC SUPP COMP REP	A
34E	NCR 500 COMPUTER REPAIRER	A
34F	DSTE REPAIRER	A
34G	FIRE CONTROL COMP REPAIRER	A
34H	ADMSE REPAIRER	A
34J	UNIVAC, DCT SYSTEM REPAIRER	A
34K	IBM 360 REPAIRER	A
34Z	ADP MAINTENANCE SUPERVISOR	A
35	USMC MOTOR TRANSPORT	N
35A	TAC INTELL OFFICER	A
35B	ELECTRONIC INSTRUMENT REPAIR/STRATEGIC INTELL OFFICER	A
35C	IMAGERY EXPOITATION	A
35E	SPECIAL ELEC DEVICE REPAIRER	A
35F	NUC WEAPONS ELEC SPEC	A
35G	BIOMEDICAL EQUIP SPEC, BASIC	A
35H	CALIBRATION SPEC	A
35K	AVIONIC MECHANIC	A
35L	AVIONIC COMM EQUIP REPAIRER	A
35M	AVIONIC NAV/FLT CONT EQIP REP	A
35P	AVIONIC EQUIP MAINT SUPERVISOR	A
35R	AVIONIC SPECIAL EQUIP REPAIRER	A
35U	BIOMED EQUIP SPEC, ADVANCED	A
361	CABLE/ANTENNA INSTALLER	F
362	MISSLE CONT COMM SYS TECH	F
36A	COUNTER INTELL	A
36B	HUMAN INTELL	A
36C	WIRESYS INSTLLER/OPERATOR	A
36D	ANTENNA INSTALLER	A
36E	CABLE SPLICER	A
36H	DIAL/MAN CEN OFFICER REPAIRER	A
36K	TAC WIRE OPS SPEC	A

NAME	DESCRIPTION	SERVICE FLAGS
36L	ELEC SWITCH SYS REPAIRER	A
37A	TAC SIG INTEL EW	A
37B	STRT SIGNALS INTELL	A
391	MAINT SYS ANALYSIS TECH	F
392	MAINTENANCE SCHEDULING TECH	F
40	USMC DATA SYSTEMS	N
4016	MAINTENANCE STAFF OFFICER	F
4024	AIRCRAFT MAINT OFFICER	F
404	AEROSPACE PHOTO SYS SPECIALIST	F
4054	MUNITIONS OFFICER	F
4096	AEROSPACE MAINT DIRECTOR	F
40A	PERSONNEL MNGMT	A
41	NAVY CHAPLAIN CORPS OFFICER/USMC EXCHANGE	N
411	MISSLE FACILITIES TECH	F
41A	PERSONNEL STAFF	A
41B	TOPOGRAPHIC INST REPAIR SPEC/RECRUITMENT	A
41C	FIRE CONTROL INST REPAIRER	A
41E	AUDIO-VISUAL EQUIP REPAIRER	A
41G	AERIAL SURV PHOTO EQ REP(RES)	A
41J	OFFICE MACH REPAIRER	A
41K	REPRO EQUIP REPAIR SPEC	A
423	AIR ACCESORY SYS SPEC	F
426	AIRCRAFT PROPULSION SPEC	F
427	AIRFRAME REPAIR SPEC	F
42A	ADMIN/PERS SYS MNGMT	A
42B	POSTAL/COURIER SERVICE	A
42C	ORTHOTIC SPEC	A
42D	DENTAL LAB SPEC/PSYCHOLOGICAL EVALUATION	A
42E	OPTICAL LABORATORY SPEC	A
43	USMC PUBLIC AFFAIRS	N
431	AIRLIFT AIRCRAFT MAINT SP	F
43A	CLUB MANAGEMENT	A
43B	COMM SVCS MNGMT	A
43C	MORALE SUPPORT	A
43D	ARMY BAND	A
43E	PARACHUTE RIGGER	A
43M	FABRIC REPAIR SPEC	A
44	USMC LEGAL SERVICES	N
44A	FINANCE/ACCTG OFFICER	A
44B	METAL WORKER/ACCOUNTING OFFICER	A
44C	DISBURSING OFFICER	A
44E	MACHINIST	A
45A	COMPTROLLER	A
45B	SMALL ARMS REPAIRER/PROGRAM-BUDGET OFFICER	A
45C	MANAGEMENT OFFICER	A
45D	SELFPROP FLD ART TURRET MECH	A
45E	XM1 TANK TURRET MECHANIC	A
45K	TANK TURRET REPAIRER	A
45L	ARTILLERY REPAIRER	A
45N	M60A1/A3 TANK TURRET MECH	A
45R	M60A2 TANK TURRET MECH	A
45T	IMP TOW VEHICLE TURRET MECH	A
45Z	ARMAMENT/FIRE CONT MAINT SUP	A
46	USMC TRAINING/AUDIOVISUAL SUPP	N
461	MUNITIONS SYSTEMS SPEC	F
462	AIR ARMAMENT SYS SPEC	F
463	NUCLEAR WEAPONS TECH	F

NAME	DESCRIPTION	SERVICE FLAGS
464	EXPLOSIVE ORDNANCE DISP TECH	F
46A	PUBLIC AFFAIRS OFFICER	A
46B	BROADCAST OFFICER	A
46N	PERSHING ELEC-MECH REPAIRER	A
472	BASE VEHICLE EQUIP MECH	F
48A	SECURITY ASSIST OFFICER	A
48B	PSYCH OPS OFFICER	A
48C	ATTACHE	A
48D	CIVIL AFFAIRS OFFICER	A
48F	CIVIL-MIL OPS OFFICER	A
48G	POLITICO-MIL AFFAIRS OFF	A
491	INFORMATION SYS OPERATOR	F
4916	INFORMATION SYS STAFF OFF	F
4924	INFO SYS PROGRAMMING/ANALYSIS	F
4934	INFORMATION SYS ENGINEER	F
4944	INFORMATION SYS OFFICER	F
4996	INFORMATION SYS DIRECTOR	F
49AA	ORSA OFFICER	A
51	NAVY CIV ENG CORPS OFFICER	N
51A	RESEARCH/DEVELOP COORD	A
51B	CARPENTRY-MASONARY SPEC/TEST AND EVALUATION OFFICER	A
51C	STRUCTURES SPEC	A
51G	MATERIAL QUALITY SPEC	A
51H	CONSTRUCTION ENGINEERING.SUP	A
51K	PLUMBER	A
51M	FIREFIGHTER	A
51N	WTR TREAT/PLUMB SYS SPEC	A
51P	UTILITIES ENGINEERING SUPER	A
51R	ELECTRICIAN	A
51T	TECH ENGINEERING SUPERVISOR	A
51Z	GEN ENGINEERING SUPERVISOR	A
52A	NUCLEAR WEPONS STAFF	A
52B	NUCLEAR WEAPONS RESEARCH	A
52C	UTILITIES EQUIP REPAIRER	A
52D	POWER GEN EQUIP REPAIRER.	A
52E	PRIME POWER PROD SPEC	A
52G	TRANSMISSION & DISTRIB SPEC	A
53A	SOFTWARE ENG OFFICER	A
53B	INDUST GAS PROD SPEC(RES)/HARDWARE ENG OFFICER	A
53C	AUTOMATION MNGMT OFFICER	A
542	ELEC POWER PRODUCTION TECH	F
545	CE CONTROLS SYS TECH	F
54A	OPS,PLANS,TRNING OFF	A
54C	SMOKE AND FLAME SPEC/FORCE DEVELOPMENT	A
54E	CHEMICAL OPERATIONS SPEC	A
54Z	CHEMICAL SENIOR SERGAENT	A
55	USMC BAND	N
551	CONSTRUCTION EQUIP OPERATOR	F
5516	CIVIL ENGINEERING STAFF OFF	F
552	CARPENTER/MASONARY SPEC	F
5525	CIVIL ENGINEERING OFFICER	F
553	ENGINEERING ASSITANT TECH	F
554	CE RESOURCE MGMT SPEC	F
555	PRODUCTION CONTROL TECH	F
5596	CIVIL ENGINEER DIRECTOR	F
55A	JUDGE ADVOCATE	A
55B	AMMUNITION SPECIALIST/MILITARY JUDGE	A

NAME	DESCRIPTION	SERVICE FLAGS
55D	EXPLOSIVE ORDNANCE DISP SPEC	A
55G	NUC WEAPON MAINT SPEC	A
55X	AMMUNITION INSPECTOR	A
55Z	AMMUNITION SUPERVISOR	A
566	ENVIRONMENTAL SUPPORT TECH	F
56A	CMND/UNIT CHAPLAIN	A
56D	CLINICAL PASTORAL EDUCATOR	A
57	USMC NBC DEFENSE	N
571	FIRE PROTECTION SPEC	F
5716	CARTOGRAPHIC/GEODETIC STAFF	F
5734	CARTOGRAPHIC/GEODETIC OFF	F
57E	LAUNDRY/BATH SPEC	A
57F	GRAVES REGISTRATION SPEC	A
57H	TERMINAL OPERATIOS COORD	A
58	USMC MP/CORRECTIONS	N
59	USMC ELECTRONICS MAINTENANCE	N
591	BOATMASTER	F
60	USMC AIRCRAFT MAINTENANCE	N
6016	TRANSPORTATION STAFF OFFICER	F
602	FREIGHT TRAFFIC SPEC	F
603	VEHICLE OPERATIONS SPEC	F
605	AIR CARGO/PASS SPEC	F
6054	TRANSPORTATION OFFICER	F
60A	OPERATIONAL MED OFFICER	A
60B	NUCLER MED OFFICER	A
60C	PREVENTIVE MED OFFICER	A
60D	OCCUPATIONAL MED OFFICER	A
60E	GENERAL MED OFFICER	A
60F	PULMONARY DISEASE OFFICER	A
60G	GASTROENTEROLOGIST	A
60H	CARDIOLOGIST	A
60J	OB/GYN	A
60K	UROLOGIST	A
60L	DERMATOLOGIST	A
60M	ALLERGIST/CLIN IMMUNOL	A
60N	ANESTHESIOLOGIST	A
60P	PEDIATRICIAN	A
60Q	PEDIATRIC CARDIOLOGIST	A
60R	CHILD NEUROLOGIST	A
60S	OPHTHALMOLOGIST	A
60T	OTORHINOLARYNGOLOGIST	A
60U	CHILD PSYCHIATRIST	A
60V	NEUROLOGIST	A
60W	PSYCHIATRIST	A
60Z	HEMATOLOGIST	A
61	NAVY LIMDU OFFICER SURFACE/USMC AIRCRAFT MAINTENANCE	N
611	SERVICES SPEC	F
612	MEATCUTTER	F
61A	NEPHROLOGIST	A
61B	WATERCRAFT OPERATOR/MEDICAL ONCOLOGIST	A
61C	WATERCRAFT ENGINEER/ENDOCRINOLOGIST	A
61D	RHEUMATOLOGIST	A
61E	CLINICAL PHARMACOLOGIST	A
61F	MARINE HULL REPAIRER/INTERNIST	A
61G	INFECTIOUS DIS OFFICER	A
61H	FAMILY PHYSICIAN	A
61J	GENERAL SURGEON	A

NAME	DESCRIPTION	SERVICE FLAGS
61K	THORACIC SURGEON	A
61L	PLASTIC SURGEON	A
61M	ORTHOPEDIC SURGEON	A
61N	FLIGHT SURGEON	A
61P	PHYSIATRIST	A
61Q	THERAPUTIC RADIOLOGIST	A
61R	DIAGNOSTIC RADIOLOGIST	A
61S	RADIOLOGIST	A
61T	ANATOMICAL PATHOLOGIST	A
61U	PATHOLOGIST	A
61V	CLINICAL PATHOLOGIST	A
61W	PERIPH/VASCULAR SURGEON	A
61Z	MARINE SENIOR SERGEANT/NEUROSURGEON	A
62	NAVY LIMDU OFFICER SUB	N
6216	SERVICES STAFF OFFICER	F
622	FOOD SERVICE SPEC	F
6224	SERVICES OPS OFFICER	F
6234	SERVICES SALES OFFICER	F
6244	FOOD SERVICE OFFICER	F
62A	EMERGENCY PHYSICIAN	A
62B	CONSTRUCTION EQUIP REPAIRER	A
62E	HEAVY CONSTRUCTION EQUIP OPER	A
62F	LIFTING/LOADING EQUIP OPER	A
62G	QUARRYING SPEC	A
62H	CONCRETE/ASPHALT EQUIP OPER	A
62J	GEN CONSTRUCTION EQUIP OPER	A
62N	CONSTRUCTION EQUIP SUP	A
63	NAVY LIMDU OFFICER AVIATION/USMC AVIONICS	N
631	FUEL SPECIALIST	F
63A	DENTAL OFFICER	A
63B	LIGHT WHEEL VEHICLE MECH/GENERAL DENTAL OFFICER	A
63D	PERIODONTIST	A
63E	XM1 TANK SYS MECHANIC/ENDODONTIST	A
63F	PROSTHODONTIST,FIXED	A
63G	FUEL-ELEC SYS REPAIRER/PROSTHODONTIST,REMOVEABLE	A
63H	TRACK VEHICLE REPAIRER/PREV DENISTRY-DENTAL PUBLIC HEALTH	A
63J	QTRMSTR/CHEM EQUIP REPAIRER	A
63K	PEDODONTIST	A
63M	ORTHODONTIST	A
63N	M60A1/A3 TANK SYS MECH/ORAL SURGEON	A
63P	ORAL PATHOLOGIST	A
63R	M60A2 TANK SYS MECH/EXECUTIVE DENTAL OFFICER	A
63S	HEAVY WHEEL VEHICLE MECH	A
63T	IMP TOW VEHICLE SYS MECH	A
63W	WEP SUP RADAR/WHEEL VECH REP	A
63Y	TRACK VEHICLE MECHANIC	A
63Z	MECH MAINT SUPERVISOR	A
64	NAVY LIMDU OFFICER OTHER	N
6416	SUPPLY MGMT STAFF OFFICER	F
6424	SUPPLY OPS OFFICER	F
645	INVENTORY MGMT SPEC	F
64A	VETERINARY SVCS OFFICER	A
64B	VETERINARY STAFF OFFICER	A
64C	MOTOR TRANSPORT OPERATOR/VET LAB ANIMAL MED OFFICER	A
64D	VETERINARY PATHOLOGIST	A
64E	VETERINARY MICROBIOLOGIST	A
64F	VET COMP MED OFFICER	A

NAME	DESCRIPTION	SERVICE FLAGS
64Z	TRANSPORTATION SENIOR SGT	A
65	NAVY LIMDU OFFICER SUP,CEC,JAG/USMC AVIATION ORDINANCE	N
651	CONTRACTING SPEC	F
6516	ACQUISITION CONT/MANUFAC STAFF	F
6524	PRODUCTION/MANUFACTURING OFF	F
6534	AQUISITION CONTRACTING OFFICER	F
6544	MANUFACTURING ENG OFFICER	F
6596	ACQUISITION CONT/MANUFAC DIR	F
65A	OCCUPATIONAL THERAPIST	A
65B	LOCOMOTIVE REPAIRER(RES)/PHYSICAL THERAPIST	A
65C	HOSPITAL DIETICIAN	A
65D	RAILWAY CAR REPAIRER (RES)	A
65E	AIRBRAKE REPAIR(RES)	A
65F	LOCOMOTIVE ELECTRICIAN(RES)	A
65G	RAILWAY SECTION REPAIRER(RES)	A
65H	LOCOMOTIVE OPERATOR(RES)	A
65J	TRAIN CREWMBR(RESERVE)	A
65K	RAILWAY MVMNT COORD (RESERVE)	A
65Z	RAILWAY SENIOR SGT(RESERVE)	A
661	LOGISTICS PLANS TECH	F
6616	LOGISTICS PLANS/PROGS STAFF	F
6624	LOGISTICS PLANS/PROGS OFF	F
66A	NURSE ADMINISTRATOR	A
66B	COMMUNITY HEALTH NURSE	A
66C	PSYCH/MENTAL HEALTH NURSE	A
66D	PEDIATRIC NURSE	A
66E	OPERATING RM NURSE	A
66F	NURSE ANESTHETIST	A
66G	OB/GYN NURSE	A
66H	MED-SURG NURSE	A
66J	CLINICAL NURSE	A
6716	ACCT/FINANCE STAFF OFFICER	F
672	FINANCIAL MGMT SPEC	F
6724	ACCT/FINANCE OFFICER	F
673	AUDITING SPEC	F
6736	BUDGET OFFICER	F
6746	COST ANALYSIS OFFICER	F
6756	COMPTROLLER STAFF OFFICER	F
6784	AUDITOR	F
6796	AUDITOR, STAFF	F
67A	HEALTH CARE ADMINISTRATOR	A
67B	FIELD MEDICAL ASSISTANT	A
67C	HEALTH SERVICES COMPTROLLER	A
67D	BIOMED INFO SYS OFFICER	A
67E	PATIENT ADMIN OFFICER	A
67F	HEALTH SVCS PERS MNGER	A
67G	AIRPLANE REPAIRER	A
67H	HLTH SVCS PLNS,OPS,INTEL,TNG	A
67J	AEROMED EVAC OFFICER	A
67K	HEALTH SVCS MATERIEL OFF	A
67L	HEALTH FAC PLANNING OFF	A
67N	UTILITY HELIOCOPTER REPAIRER	A
67T	TAC TRANS HELIO REPAIRER	A
67U	MEDIUM HELICOPTER REPAIRER	A
67V	OBSV/SCOUT HELO REPAIRER	A
67W	AIRCRAFT QUALITY SUPERVISOR	A
67X	HEAVY LIFT HELICOPTER REP	A

NAME	DESCRIPTION	SERVICE FLAGS
67Y	ATTACK HELICOPTER REPAIRER	A
67Z	AIRCRAFT MAINT SENIOR SERGAENT	A
68	USMC WEATHER SERVICE	N
68A	MICROBIOLOGIST	A
68B	AIRCRAFT POWERPLANT REPAIRER	A
68BA	NUC MED SCIENCE OFFICER	A
68C	BIOCHEMIST	A
68D	AIRCRAFT POWERTRAIN REPAIRER/PARASITOLOGIST	A
68E	IMMUNOLOGIST	A
68F	AIRCRAFT ELECTRICIAN/CLIN LAB OFF-LAB MANAGER	A
68G	AIRCRAFT STRUCTURAL REPAIRER/ENTOMOLOGIST	A
68H	AIRCRAFT PNEUDRAULICS REPAIRER/PHARMACY OFFICER	A
68J	AIRCRAFT FIRE CONTROL REPAIRER/PHYSIOLOGIST	A
68K	AIRCRAFT COMPONENTS REPAIR SUPP/OPTOMETRY OFFICER	A
68L	PODIATRIST	A
68M	AIRCRAFT WEAPON SYS REPAIRER/AUDIOLOGIST	A
68N	ENVIRONMENTAL SCIENCE OFF	A
68P	SANITARY ENGINEER	A
68R	SOCIAL WORK OFFICER	A
68S	PSYCHOLOGIST	A
68T	RESEARCH PSYCHOLOGIST	A
68U	PSYCHOLOGY ASSOCIATE	A
691	COST/MGMT ANALYSIS SPEC	F
6916	COST/MGMT ANALYSIS STAFF OFF	F
6924	COST/MGMT ANALYSIS OFFICER	F
70	USMC AIRFIELD SERVICES	N
701	CHAPEL MANAGER	F
7016	EXECUTIVE SUPPORT STAFF OFF	F
702	ADMINISTRATION SPECIALIST	F
7024	EXECUTIVE SUPPORT OFFICER	F
703	REPROGRAPHIC TECH	F
7034	ADMINISTRATION MGMT OFFICER	F
7046	ADMINISTRATION MGMT STAFF	F
705	LEGAL SERVICES TECH	F
71	NAVY WARRANT OFFICER SURFACE	N
71A	AVIATION LOGISTICS OFFICER	A
71C	STENOGRAPHER	A
71D	LEGAL CLERK	A
71E	COURT REPORTER	A
71G	PATIENT ADMIN SPEC	A
71L	ADMINISTRATIVE SPEC	A
71M	CHAPEL ACTIVITIES SPEC	A
71N	TRAFFIC MNGMT COORDINATOR	A
71P	FLT OPERATIONS COORDINATOR	A
71Q	JOURNALIST	A
71R	BROADCAST JOURNALIST	A
72	NAVY WARRANT OFFICER SUBMARINE/USMC AIR CNTL,SUPP,ANTI-AIR	N
72A	COMM-ELEC MAT MNGMT	A
72E	TELECOMM CENTER OPERATOR	A
72G	DATA COMM SWITCH CEN SPEC	A
72H	CENTRAL OFFICE OPS OPERATOR	A
73	NAVY WARRANT OFFICER AVIATION/USMC AIR TRF CNTL-ENL FLT CREW	N
7316	PERSONNEL PROGS STAFF OFFICER	F
732	CAREER ADVISOR	F
7324	PERSONNEL PROGRAMS OFFICER	F
733	MANPOWER MGMT TECH	F
734	SOCIAL ACTIONS TECH	F

NAME	DESCRIPTION	SERVICE FLAGS
7364	SOCIAL ACTION OFFICER	F
7376	SOCIAL ACTIONS STAFF OFF	F
73A	MSL MTRIEL MNGMT OFFICER	A
73C	FINANCE SPEC	A
73D	ACCOUNTING SPEC	A
73Z	FINANCE SENIOR SERGAENT	A
74	NAVY WARRANT OFFICER OTHER	N
741	FITNESS/REC SPEC	F
7416	MANPOWER MGMT STAFF OFF	F
742	OPEN MESS MGMT SPEC	F
7424	MANPOWER MGMT OFFICER	F
74A	CHEMICAL OFFICER	A
74B	CARD/TAPE WRITER(RES)	A
74D	COMPUTER/MACHINE OPERATOR	A
74F	PROGRAMMER/ANALYST	A
74Z	DATA PROCESSING NCO	A
75	NAVY WARRANT OFFICER SUP,CE,PA//USMC PILOTS,NAVAL FLT OFF	N
751	EDUCATION/TRAINING SPEC	F
7516	EDUCATION/TRAINING STAFF OFF	F
7524	EDUCATION/TRAINING OFFICER	F
753	COMBAT ARMS TRAIN/MAINT SPEC	F
75A	MUNITION MTRIEL MNGMT OFFICER	A
75B	PERSONNEL ADMIN SPEC/CONV MUNITION MAT MNGMT OFFICER	A
75C	PERSONNEL MNGMT SPEC/NUC WEAPONS MAT MNGMT OFFICER	A
75D	PERSONNEL RECORDS SPEC/EXPLOSIVE ORD DISPO OFFICER	A
75E	PERSONNEL ACTION SPEC	A
75Z	PERSONNEL SENIOR SGT	A
76C	EQUIP RECORDS/PARTS SPEC	A
76J	MEDICA SUPPLY SPEC	A
76P	MATERIEL CONT/ACCT SPEC	A
76V	MATERIAL STOR/HANDLING SPEC	A
76W	PETROLEUM SUPPLY SPEC	A
76X	SUBSISTENCE SUPPLY SPEC	A
76Y	UNIT SUPPLY SPECIALIST	A
76Z	SENIOR SUPPLY SGT	A
791	HISTORIAN/PUBLIC AFFAIRS	F
7916	PUBLIC AFFAIRS STAFF OFF	F
7924	PUBLIC AFFAIRS OFFICER	F
79D	RE-ENLISTMENT NCO	A
80	USMC QUALITY ASSURANCE(SUBS)	N
8016	INTELL PLAN,PROG,RES,SYS STAFF	F
8025	HUMAN RESOURCES INTELL OFF	F
8035	SIGNALS INTELL OFFICER	F
8045	IMAGERY INTELL OFFICER	F
8075	INTELL APPLICATIONS OFFICER	F
8085	TARGET INTELL OFFICER	F
8096	INTELLIGENCE DIRECTOR	F
81	USMC GUARD	N
811	SECURITY POLICE	F
8116	SECURITY POLICE STAFF OFFICER	F
8124	SECURITY POLICE OFFICER	F
81A	PETROLEUM MNGMT OFFICER	A
81B	TECH DRAFTING SPEC	A
81C	CARTOGRAPHER	A
81E	ILLUSTRATOR	A
81Z	TOPOGRAPHIC ENGINEER SUPER	A
82	USMC EDUCATION ASSISTANT	N

NAME	DESCRIPTION	SERVICE FLAGS
821	SPECIAL INVESTIGATIONS TECH	F
8216	SPECIAL INVESTIGATIONS STAFF	F
8224	SPECIAL INVESTIGATIONS OFF	F
82A	SUBSISTENCE SUPPLY OFF	A
82B	CONSTRUCTION SURVEYOR	A
82C	FLD ARTILLERY SURVEYOR/FOOD SERVICE OFFICER	A
82D	TOPOGRAPHIC SURVEYOR/COMMISARY MNGMT OFFICER	A
83E	PHOTO & LAYOUT SPEC	A
83F	PHOTOLITHOGRAPHER	A
84	USMC RECRUITER/CAREER PLANNER	N
84B	STILL PHOTO SPEC	A
84C	MOTION PICTURE SPEC	A
84F	AUDIO/TV SPECIALIST	A
84T	TV/RADIO BDCST OPS CHIEF	A
84Z	PUB AFFAIRS/AUDIOVIS CHIEF	A
85	USMC DI/INST/COUNS	N
86	USMC RECON/INTERP	N
87	USMC INFANTRY OPS SPEC	N
871	BAND SPEC	F
8716	BAND STAFF OFFICER	F
872	INSTRUMENTALIST	F
8724	BAND OFFICER	F
88	USMC FIREFIGHTER	N
8816	JUDGE ADVOCATE, STAFF	F
8824	JUDGE ADVOCATE	F
89	USMC PERS SUPP SPEC	N
8916	STAFF CHAPLAIN	F
8924	CHAPLAIN	F
90	USMC GRAVES REGISTRATION SPEC	N
9016	HEALTH SERVICES ADMIN, STAFF	F
902	MEDICAL SERVICE TECH	F
9025	HEALTH SERVICES ADMINISTRATOR	F
903	NUCLEAR MEDICINE TECH	F
905	PHARMACY TECH	F
906	MEDICAL ADMIN SPEC	F
907	BIO-ENVIRON ENGINEERING SPEC	F
908	ENVIORMENTAL MED TECH	F
90D	COLLEGE TRAINEE	A
911	AEROSPACE PHYSIOLOGY SPEC	F
9116	BIOENVIRONMENTAL ENG, STAFF	F
912	OPTOMETRY TECH	F
9125	BIOENVIRONMENTAL ENGINEER	F
913	BIOMED/OCCUP THERAPY SPEC	F
9136	MEDICAL ENTOMOLOGIST	F
914	MENTAL HEALTH TECH	F
9146	STAFF BIOMED SCIENTIST	F
915	MEDICAL MATERIEL SPEC	F
9156	BIOMEDICAL LAB OFFICER	F
9166	AEROSPACE PHYSIOLOGIST	F
9176	HEALTH PHYSICIST	F
918	BIOMEDICAL EQUIPMENT SPEC	F
9186	CLINICAL PSYCHOLOGIST	F
919	ORTHOTIC TECH	F
9196	CLINICAL SOCIAL WORKER	F
91A	MAINTENANCE MNGMT OFFICER	A
91B	MEDICAL SPECIALIST/ARMAMENT-MECH MAINTENANCE	A
91C	CLINICAL/PT CARE SPEC	A

NAME	DESCRIPTION	SERVICE FLAGS
91D	OPERTING ROOM SPEC	A
91E	DENTAL SPEC	A
91F	PHYS THERAPY/PSYCHIATRIC SPEC	A
91G	BEHAVIORAL SCIENCES SPEC	A
91H	ORTHOPEDIC SPEC	A
91L	OCCUPATIONAL THERAPY SPEC	A
91N	CARDIAC SPEC	A
91P	X-RAY SPECIALIST	A
91Q	PHARMACY SPEC	A
91R	VETERINARY SPECIALIST	A
91S	ENVIRONMENTAL HEALTH SPEC	A
91T	ANIMAL CARE SPECIALIST	A
91U	ENT SPEC	A
91V	RESPIRATORY SPEC	A
91W	NUCLEAR MED SPECIALIST	A
91Y	EYE SPEC	A
9216	DIETITIAN	F
9226	OCCUPATIONAL THERAPIST	F
9236	PHYSICAL THERAPIST	F
924	HISTO/MED LAB TECH	F
9246	PHARMACIST	F
925	CYTOTECHNOLOGY SPEC	F
9256	OPTOMETRIST	F
926	DIET THERAPY SPEC	F
9266	BIOMEDICAL SPECIALIST	F
9276	PODIATRIST	F
9286	PHYSICIAN ASSISTANT	F
9296	ENVIRONMENTAL HEALTH OFFICER	F
92A	SUPPLY/SVC MNGMT OFFICER	A
92B	MED LAB SPEC/MAT MNGMT OFFICER	A
92C	PETROLEUM LAB SPEC/DEPOT OPS-STORAGE OFFICER	A
92D	CHEMICAL LAB SPEC/AERIAL DELIVERY AND MATERIAL OFFICER	A
92E	MEMORIAL ACTIVITIES OFFICER	A
9316	STAFF CLINICIAN	F
9326	GENERAL PRACTICE PHYSICIAN	F
9346	FAMILY PHYSICIAN	F
9356	AEROSPACE MEDICINE PHYSICIAN	F
9366	PEDIATRICIAN	F
9376	PHYSICAL MEDICINE PHYSICIAN	F
9386	INTERNIST	F
9396	EMERGENCY PHYSICIAN	F
93E	METEOROLOGICAL OBSERVER	A
93F	FLD ART METEOROLOGICAL CREW	A
93H	ATC TOWER OPERATOR	A
93J	ATC RADAR CONTROLLER	A
9416	SURGEON	F
9426	UROLOGIST	F
9436	OPHTHALMOLOGIST	F
9446	OTORHINOLARYNGOLOGIST	F
9486	ORTHOPEDIC SURGEON	F
9496	OBSTETRICIAN/GYNECOLOGIST	F
94B	FOOD SERVICE SPEC	A
94F	HOSPITAL FOOD SERVICE SPEC	A
9526	PATHOLOGIST	F
9536	DIAGNOSTIC RADIOLOGIST	F
9556	DERMATOLOGIST	F
9566	ANESTHESIOLOGIST	F

NAME	DESCRIPTION	SERVICE FLAGS
9576	NEUROLOGIST	F
9586	PSYCHIATRIST	F
9596	RADIOTHERAPIST	F
95A	TRANSPORTTION MNGMT	A
95B	MILITARY POLICE/TRAFFIC MANAGEMENT	A
95C	CORRECTIONAL SPEC/MARINE AND TERMINAL OPERATIONS	A
95D	MOTOR/RAIL TRANSPORTATION	A
96	USMC SPECIAL EDUCATION PROG	N
9626	SCIENTIST, MEDICAL/BIOMEDICAL	F
9636	ALLERGIST	F
96B	INTELLIGENCE ANALYST	A
96C	INTERROGATOR	A
96D	SPECIAL AGNT/IMAGE INT	A
96H	AERIAL SENSOR SPEC	A
96Z	INTELLIGENCE SENIOR SERGAENT	A
9716	NURSING ADMINISTRATOR	F
9726	MENTAL HEALTH NURSE	F
9736	OPERATING ROOM NURSE	F
9746	NURSE ANESTHETIST	F
9756	CLINICAL NURSE	F
9776	NURSE-MIDWIFE	F
9786	ENVIRONMENTAL HEALTH NURSE	F
97A	PROCURMENT MNGMT OFFICER	A
97B	COUNTERINTELLIGENCE AGENT/PROCUREMENT OFFICER	A
97C	AREA INTELLIGENCE SPECIALIST/PRODUCTION OFFICER	A
981	DENTAL ASSISTANT	F
9816	DENTAL STAFF OFFICER	F
982	DENTAL LAB TECH	F
9826	DENTAL OFFICER, GENERAL	F
9836	ORAL SURGEON	F
9846	PERIODONTIST	F
9856	PROSTHODONTIST	F
9866	ORTHODONTIST	F
9876	ORAL PATHOLOGIST	F
9886	ENDODONTIST	F
9896	PEDODONTIST	F
98C	EW/SIGINT ANALYST	A
98G	EW/SIGINT VOICE INTERCEPTOR	A
98J	EW/SIGINT NONCOMM INTERCEPTOR	A
98Z	EW-SIG INT CHIEF	A
990	AIRMAN AWAITING DIS/SEP/RET	F
991	AIRMAN AIDE	F
9936	VETERINARY SCIENTIST	F
9946	VETERINARY CLINICAL SPECIALIST	F
995	COM INFO/COURIER/MTI/HON GRD	F
996	ALERT FACILITY CONTROLLER	F
997	CORRECTION CUSTODY SPEC	F
AA	AIRMAN APPRENTICE	N
AB	AVIATION BOATSWAIN'S MATE	N
AC	AIR TRAFFIC CONTROLLER	N
AD	AVIATION MACHINIST'S MATE	N
AE	AVIATION ELECTRICIAN'S MATE	N
AG	AEROGRAPHER'S MATE	N
AK	AVIATION STOREKEEPER	N
AM	AVIATION STRUCTURAL MECH	N
AN	AIRMAN	N
AO	AVIATION ORDNANCEMAN	N

NAME	DESCRIPTION	SERVICE FLAGS
AQ	AVIATION FIRE CONTROL TECH	N
AR	AIRMAN RECRUIT	N
AS	AVIATION SUPPORT EQUIP TECH	N
AT	AVIATION ELECTRONICS TECH	N
AW	AVIATION ANTISUB WARFARE OP	N
AX	AVIATION ANTISUB WARFARE TECH	N
AZ	AVIATION MAINTENANCE ADMIN	N
BM	BOATSWAINS MATE	N
BT	BOILER TECHNICIAN	N
BU	BUILDER	N
CE	CONSTRUCTION ELECTRICIAN	N
CM	CONSTRUCTION MECHANIC	N
CT	CRYPTOLOGIC TECHNICIAN	N
DK	DISBURSING CLERK	N
DM	ILLUSTRATOR DRAFTSMAN	N
DP	DATA PROCESSING TECHNICIAN	N
DS	DATA SYSTEMS TECHNICIAN	N
DT	DENTAL TECHNICIAN	N
EA	ENGINEERING AID	N
EM	ELECTRICIAN'S MATE	N
EN	ENGINEMAN	N
EO	EQUIPMENT OPERATOR	N
ET	ELECTRONICS TECHNICIAN	N
EW	ELECTRONICS WARFARE TECHNICIAN	N
FA	FIREMAN APPRENTICE	N
FN	FIREMAN	N
FR	FIREMAN RECRUIT	N
FT	FIRE CONTROL TECHNICIAN	N
GM	GUNNER'S MATE	N
GS	GAS TURBINE SYSTEMS TECHNICIAN	N
HM	HOSPITAL CORPSMAN	N
HT	HULL MAINTENANCE TECHNICIAN	N
IC	INTERIOR COMM ELECTRICIAN	N
IM	INSTRUMENTMAN	N
IS	INTELLIGENCE SPECIALIST .	N
JO	JOURNALIST	N
LI	LITHOGRAPHER	N
LN	LEGALMAN	N
MA	MASTER AT ARMS	N
ML	MOLDER	N
MM	MACHINIST'S MATE	N
MN	MINEMAN	N
MR	MACHINE REPAIR	N
MS	MESS MANAGMENT SPECIALIST	N
MT	MISSLE TECHNICIAN	N
MU	MUSICIAN	N
NC	NAVY COUNSELOR	N
NS	SPECIAL NON-IDENTIFIED STRIKER	N
OM	OPTICALMAN	N
OS	OPERATIONS SPECIALIST	N
OT	OCEAN SYSTEMS TECHNICIAN	N
PC	POSTAL CLERK	N
PH	PHOTOGRAPHER'S MATE	N
PM	PATTERNMAKER	N
PN	PERSONNELMAN	N
PR	AIRCREW SURVIVAL EQUIP-MAN	N
QM	QUARTERMASTER	N

NAME	DESCRIPTION	SERVICE FLAGS
RM	RADIOMAN	N
RP	RELIGIOUS PROGRAM SPECIALIST	N
SA	SEAMAN APPRENTICE	N
SH	SHIP'S SERVICEMAN	N
SK	STOREKEEPER	N
SM	SIGNALMAN	N
SN	SEAMAN	N
SR	SEAMAN RECRUIT	N
ST	SONAR TECHNICIAN	N
SW	STEELWORKER	N
TD	TRADEVMAN	N
TM	TORPEDOMAN'S MATE	N
UT	UTILITIESMAN	N
WP	WOMEN PETTY OFFICERS	N

SOURCE OF ADM CODE	DESCRIPTION	FLAGS	SERVICE FLAG	ARMY CODE	AIRFORCE CODE	NAVY CODE
ABS	DIRECT,ABSENT SICK	011	AF	0	20	
CAN	CANCEL ADMISSION	7	AFN			
CAS	DIRECT, CASUAL	1	F		01	
CBC	BATTLE CASUALTY, CRO	502	A	C		
CDA	DEAD ON ARRIVAL, AD MILITARY CRO	512	A	C		
CDO	DEAD ON ARRIVAL, NON AD, CRO	502	A	C		
CDS	DISABILITY SEPARATION, CRO	512	A	C		
COT	OTHER CARDED FOR RECORD ONLY	502	A	C		
CRO	CARDED FOR RECORD ONLY	502	F		21	
DIR	DIRECT ADMISSION	1	AFN	1	00	00
ERD	EMERGENCY ROOM DEATH	503	F		23	
FTM	TRANSFER FROM ANOTHER MILITARY MTF	305	N			10
FTO	TRANSFER FROM OTHER MEDICAL FACILITIES	3	N			11
LB	LIVE BIRTH	2	N			31
NB	NEWBORN THIS MTF	2	A	L		
NBD	NEWBORN WITH MOTHER DIRECT	2	N			32
NBR	NEWBORN RETAINED	4	N			34
NBT	NEWBORN WITH MOTHER FROM TRANSFER	2	N			33
NEW	LIVEBORN INFANTS (NEWBORN), THIS MTF	2	F		30	
P/S	NEWBORN TO PAY	4	A	L		
PRE	PREADMIT	600	AFN			
QTR	ADMITTED TO QUARTERS	814	F		22	
RET	NEWBORN RETAINED	4	F		34	
TAF	TRANSFER FROM USAF HOSPITAL	3	A	8		
TAR	TRANSFER FROM US ARMY HOSPITAL	3	A	6		
TDP	TRANSFER FROM USN,USAF DISPENSARY	3	A	5		
TFM	TRANSFER FROM FOREIGN MILITARY MTF	3	A	9		
TFR	TRANSFER FROM ANOTHER MILITARY MTF	305	F		10	
TNV	TRANSFER FROM USN HOSP/HOSP SHIP	3	A	7		

ABSENT STATUS (table) LIST AUG 21,1985 06:45 PAGE 1

ABSENT STATUS CODE	DESCRIPTION	FLAGS	SERVICE FLAG	ARMY BUCKET NBR	AIR FORCE BUCKET NBR	NAVY BUCKET NBR	NAVY TRANS CODE
AC	ABSENT IN CUSTODY OF CIVILIAN AUTHORITIES	21001	FN		4	4	81
AG	AWOL(MORE THAN 10 DAYS) DFR	21001	FA	2	4		
AM	ABSENT IN CUSTODY OF MILITARY AUTHORITIES	21001	FAN	2	4	4	81
AS	ABSENT SICK NON-MILITARY MTF	2110101	FA	1	4		
AW	AWOL(LESS THAN 10 DAYS)	21001	FAN	2	4	4	83
BO	BED OCCUPANT THIS MTF	1001101001	FAN	5	5	5	80
CC	COOPERATIVE CARE	20001	AN	3	1	1	81
CL	CONVALESCENT LEAVE	22000000	FAN	3	3	3	82
CR	CARDED FOR RECORD ONLY	2020101	FA				
ER	EMER ROOM DEATH	10301010	F				
MH	MEDICAL HOLDING	21001011	AN	2			30
OL	EMERGENCY LEAVE	21001	FAN	2	4	4	82
OR	ORDINARY LEAVE	21001	A	2			
OT	OTHER AUTHORIZED ABSENCE	21001	A	2			
PH	PCS HOME PENDING SEPARATION/RETIREMENT	2100101	FA	2	4		
PS	ON PASS	2001001000	FA	5	5		
PV	PCS VA HOSPITAL PENDING SEPARATION/RETIREMENT	2100111	AF	2	4		
QT	ABSENT IN QUARTERS	2140001	F		4		
SC	SUPPLEMENTAL CARE	20001000	FAN	4	2	2	81
SE	SUBSISTING ELSEWHERE/OUT	210000001	FAN	2	4	4	81
TD	TEMPORARY DUTY/SPECIAL DUTY	21000	A	2	2		

TYPE CASE (table) LIST AUG 21,1985 07:11 PAGE 1

TYPE CASE CODE	DESCRIPTION	FLAGS	ARMY CODE	ARMY/AF ITRCS MNEMONIC	AF CODES	SERVICE FLAG
AST	ASSAULT OR INTENTIONALLY INFLICTED BY ANOTHER PERSON	1	3	INJ		A
BC	OTHER BATTLE CASUALTIES CLASSIFIABLE BY DEPARTMENTAL REGULATIONS	11	1	BC		AF
DIS	DISEASE CASES AND ALL OTHER CASES NOT COVERED ELSEWHERE		D	DIS	D	AFN
EXR	INJURY SCHEMES AND EXERCISES	1	6	INJ		A
HST	DIRECT RESULT OF ACTION BY/AGAINST ORGANIZED ENEMY	01	0	BC		A
INJ	INJURY, NOT CLASSIFIABLE AS BATTLE CASUALTY	10		INJ	C	NF
LEG	RESULT OF INTERVENTION OF LEGAL AUTHORITY	11	2	INJ		A
OFF	OFF DUTY INJURY (INC LEAVE,PASS,AWOL)	1	5	INJ		A
OND	OCCURING WHILE ON DUTY	11	8	INJ		A
SLF	INJURY - INTENTIONALLY SELF-INFLICTED	1	4	INJ		A
TRN	INJURY - ALL OTHER TRAINING	11	7	INJ		A
UNK	INJURY UNK ON/OFF DUTY OR NON-MILITARY	100	9	INJ		A

LINICAL VC/MTF ODE DELETE DATE	DESCRIPTION	FLAGS	VALID WARDS	ARMY CODE	ITRCS SHORT DESC	SERVICE FLAG
AA	INTERNAL MEDICINE	0000				FN
AAA	INTERNAL MEDICINE			AA	INT MED	A
AAB	INFECTIOUS DISEASE			AU	INF DIS	A
AAC	ALLERGY			AN	ALGY/IMM	A
AAF	FP INTERNAL MEDICINE			EA	FP MED	A
AB	CARDIOLOGY	000				FN
ABA	CARDIOLOGY			AB	CARDIO	A
ABF	FP CARDIOLOGY			EA	FP MED	A
AC	CORONARY CARE UNIT	000			CCU	FN
ACA	CORONARY CARE UNIT			AB	CARDIO	A
ACF	CORONARY CARE FP			EA	FP MED	A
AD	DERMATOLOGY	000				FN
ADA	DERMATOLOGY			AD	DERM	A
ADF	DERMATOLOGY			EA	FP MED	A
AE	ENDOCRINOLOGY	000				FN
AEA	ENDOCRINOLOGY			AE	ENDOCN	A
AEF	ENDO FAM PRAC			EA	FP MED	A
AF	GASTROENTEROLOGY	000				FN
AFA	GASTROENTEROLOGY			AF	GASTRO	A
AFF	FP GASTROENTEROLOGY			EA	FP MED	A
AG	HEMATOLOGY	000				FN
AGA	HEMATOLOGY			AG	HEMAT	A
AGF	HEMA FAM PRACT			EA	FP MED	A
AH	INTENSIVE CARE (MEDICINE)	000			ICU	FN
AHA	INTENSIVE CARE UNIT (MEDICAL)			AA	ICU	A
AHF	FP MED ICU			EA	FP MED	A
AI	NEPHROLOGY	000				FN

CLINICAL SVC/MTF CODE	DESCRIPTION	FLAGS	VALID WARDS	ARMY CODE	ITRCS SHORT DESC	SERVICE FLAG
	DELETE DATE					
AAIA	NEPHROLOGY			AI	NEPHRO	A
AAJ	NEUROLOGY	000				FN
AAJA	NEUROLOGY	0000		AJ	NEURO	A
AAJF	FP NEUROLOGY			EA	FP NEURO	A
AAK	ONCOLOGY	000				FN
AAKA	ONCOLOGY			AK	ONCOL	A
AAL	PULMONARY UPPER RESPIR(NON-TB)	000				FN
AALA	PULMONARY/UPPER RESPIRATORY			AL	PUL DIS	A
AAM	RHEUMATOLOGY	000				FN
AAMA	RHEUMATOLOGY			AM	RHEUMAT	A
AAMF	RHEUM FAM PRAC			EA	FP MED	A
AAN	INTERMEDIATE CARE	000				FN
AAP	FAMILY PRACTICE					FN
AAR	ALLERGY	000				FN
AAS	PULMONARY UPPER RESPIR(TBC)	000				FN
AAZ	MEDICAL CARE N.E.C.					FN
ABA	GENERAL SURGERY	000				FN
ABAA	GENERAL SURGERY			BA	GEN SURG	A
ABB	THORACIC/CARDIOVASC SURG	000				FN
ABBA	CARD VAS THOR SURG			BB	THORAC SURG	A
ABBB	PERIPHERAL VASC			BN	PV SURG	A
ABC	INTENSIVE CARE (SURGICAL)	000				FN
ABCA	INTENSIVE CARE UNIT (SURGICAL)			BA	GEN SURG	A
ABCB	TRAUMA			BA	INT MED	A
ABCF	FP SURG ICU			EB	FP SURG	A
ABD	NEUROSURGERY	0000				FN
ABDA	NEUROSURGERY			BD	NEUROSURG	A

CLINICAL SVC/MTF CODE	DESCRIPTION	FLAGS	VALID WARDS	ARMY CODE	ITRCS SHORT DESC	SERVICE FLAG
	DELETE DATE					
ABE	OPHTHALMOLOGY	000				FN
ABEA	OPHTHALMOLOGY			HA	OPHTHAL	A
ABF	ORAL SURGERY	000				FN
ABFA	ORAL SURGERY			BE	ORAL SURG	A
ABG	OTORHINOLARYNGOLOGY	000			ENT	FN
ABGA	OTORHINOLARYNGOLOGY			HB	ENT	A
ABGF	FP OTORHINOLARYNGOLOGY			EB	FP SURG	A
ABH	PEDIATRIC SURGERY	200				FN
ABHA	PEDIATRIC SURGERY	2		BF	PED SURG	A
ABHF	PED SURG FAM PRAC			EF	FP PED	A
ABI	PLASTIC SURGERY	000				FN
ABIA	PLASTIC SURGERY			BG	PLAS SURG	A
ABJ	PROCTOLOGY	000				FN
ABJA	PROCTOLOGY			BH	PROCTO	A
ABJF	PROC FAM PRAC			BH	PROCTO	A
ABK	UROLOGY	000				FN
ABKA	UROLOGY			BI	UROLOGY	A
ABKF	FP UROLOGY			EB	FP SURG	A
ABL	HAND SURGERY			BJ	HAND SURG	FN
ABLA	HAND SURGERY			BJ	HAND SURG	A
ABLB	HEAD/NECK SURGERY			BK	H/N SURG	A
ABSK	ABSENT SICK IN NON-MILITARY HOSP	011		9J	ABSK	A
ABZ	SURGICAL CARE (SERVICE NEC)	000				FN
ABZA	ORGAN TRANSPLANT			BL	ORG TRANS	A
ABZB	SURGICAL CARE N.E.C					A
ABZC	ISR (BURN CENTER BAMC)			BZ	ISR	A
ACA	GYNECOLOGY	300				FN

CLINICAL SVC/MTF CODE	DESCRIPTION	FLAGS	VALID WARDS	ARMY CODE	IIRCS SHORT DESC	SERVICE FLAG	DELETE DATE
ACAA	GYNECOLOGY	3		CA	GYN	A	
ACAF	FP GYNECOLOGY			ED	FP GYN	A	
ACB	OBSTETRICS	300				FN	
ACBA	LABOR/DELIVERY	3		CB	OB	A	
ACBF	FP LABOR/DELIVERY			EC	FP OB	A	
ADA	PEDIATRICS	200				FN	
ADAA	PEDIATRICS	2		DA	PED	A	
ADAF	FP PEDIATRICS	2		EF	FP PED	A	
ADB	NURSERY	1000				FN	
ADBA	NURSERY	10		DB	NB	A	
ADBF	FP NURSERY	1		EF	FP PED	A	
ADC	NEONATAL ICU	000				FN	
ADCA	NURSERY (NEONATAL)	00		DB	PED	A	
ADCF	NEONATAL ICU FAM PR			EF	FP PED	A	
ADZ	PEDIATRIC CARE NEC	200				FN	
ADZA	ADOLESCENT PEDIATRICS	2		DC	ADOL PED	A	
AEA	ORTHOPEDICS	000				FN	
AEAA	ORTHOPEDICS			FA	ORTHO	A	
AEAF	FP ORTHOPEDICS			EG	FP ORTHO	A	
AEB	PODIATRY	000				FN	
AEBA	PODIATRY			FB	PODIA	A	
AEBF	FP PODIATRY			EG	FP ORTHO	A	
AFA	PSYCHIATRIC CARE			GA	PSY	FN	
AFAA	PSYCHIATRIC CARE			GA	PSY	A	
AFAF	FP PSYCHIATRIC CARE			EH	FP PSY	A	
AJA	QUARTERS	014				FN	
AJB	CARDED FOR RECORD ONLY	002				FN	

CLINICAL SVC (table) LIST AUG 21,1985 06:47 PAGE 5

CLINICAL SVC/MTF CODE	DESCRIPTION	FLAGS	VALID WARDS	ARMY CODE	IIRCS SHORT DESC	SERVICE FLAG	DELETE DATE
AJC	IN NON-FEDERAL HOSPITAL	0111				F	
AJD	PREGNANT IN QUARTERS	314				FN	
AJE	EMERGENCY ROOM DEATH	003		92		FN	
CRO	CARDED FOR RECORD ONLY	002		ZZ	CRO	A	
XXXX	RTF (RES TREAT FAC)			XX	RTF	A	

DISP TYPE (table) LIST

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DISP TYPE CODE	DESCRIPTION	FLAGS	SERVICE FLAG	ARMY CODE	AIR FORCE CODE	NAVY CODE	ARMY SHORT DESC
AWOL	ABSENT WITHOUT LEAVE OVER 10 DAYS	010	FA	D	S		AWOL
CL	DISCHARGED, CONVALSCENT LEAVE RECOMMENED	01004	N			11	
CROO	CRO - OTHER	231	A	Y			CRO
DAAF	NONDISABILITY SEPN FOR DRUG & ALCOHOL ABUSE PROG	01	A	I			NONDISAB
DAMA	DISCHARGED AGAINST MEDICAL ADVICE	5201	AF	F	F		AMA
DANF	DEATH, AUTOPSY NOT PERFORMED	2311	F		B		
DAP	DEATH, AUTOPSY PERFORMED	2311	F		/		
DETS	SEPN UP AR 635-200 ETS	01	A	L			ETS
DFT	DISCHARGE FROM TREATMENT (NON-US SERVICES PT. ONLY)	0201	FA	O	U		DISCHG
DIED	DIED	23115	N			20	
DISN	NEWBORN - DISCHARGED	0201	A	O			DISCHG
DMFS	SEPN UP AR 635-200 MEDICAL PROCUREMENT STDS	011	A	J			FAIL MED
DMT	DEATH, MATERNAL	231	A	V			EXPIRED
DNEW	NEWBORN DIED - MOTHER REMAINING	2201	A	W			EXP-HOSP
DNFS	SEPN UP AR 635-200 UNFIT/UNSUITABLE	01	A	K			UNFIT
DNN	DEATH, NEO-NATAL (LESS THAN 28 DAYS)	2211	A	Q			EXPIRED
DNSA	DEATH, NO STATEMENT AS TO AUTOPSY	2311	F		9		
DOA	CRO - DEAD ON ARRIVAL	231	A	X			EXP-CRO
DOTH	DEATH, ALL OTHER HOSPITAL	2311	A	W			EXP-HOSP
DSD	DISCHARGE FROM HOSPITAL SAME DAY	431	F		X		
DUTY	RETURNED TO DUTY (US SERVICES PT. ONLY)	0100	AF	A	A		DUTY
EFTS	DISCHARGE UNDER PROVISION OF AICR 39-6	0100	F		R		
EVAC	EVACUATED TO US	3301	F		M		
HOME	DISCHARGED TO DUTY/HOME	03012	N			10	
OTH	OTHER DISPOSITION (MILITARY PATIENTS ONLY)	010	F		T		
PDRL	PERMANENT RETIREMENT FOR PHYSICAL DISABILITY	011	FA	E	C		PDRL
SEP	OTHER SEPARATIONS	011	A	M			OTH SEPN
SWOP	SEPARATION WITHOUT SEVERANCE PAY (PEB)	011	FA	H	P		SWOP
SWPL	SEPARATION WITH SEVERANCE PAY (PEB)	011	FA	G	L		SWPL
TAF	TRANSFER TO ARMY FACILITY	3301	FA	S	K		TAF
TDRL	TEMPORARY RETIREMENT FOR PHYSICAL DISABILITY	011	FA	F	D		TDRL
TDUT	TO DUTY FROM TDRL	011	A	B			DUTY/CRO
TFF	TRANSFER TO AIR FORCE FACILITY	3301	FA	U	J		TFF
TFR	TRANSFERED	33111	N			01	
TNF	TRANSFER TO NAVY FACILITY	3301	FA	T	L		TNF
TPDR	TO PDRL FROM TDRL	011	A	C			PDRL/CRO

NAME	DESCRIPTION
99	NOT APPLICBLE
A1	LEBANON, HOSTILE
A2	LEBANON, NON-HOSTILE
B1	GRENADA, HOSTILE
B2	GRENADA, NON-HOSTILE

AUSE OF NJURY CODE	DESCRIPTION
0	AIR ACCIDENT, FIXED-WING MILITARY, BOARDING OR ALIGHTING
1	AIR ACCIDENT, FIXED-WING MILITARY, TAXIIN,TAKEOFF,LANDING ON CARRIER
2	AIR ACCIDENT, FIXED-WING MILITARY, TAKEOFF,OTHER (INC CRASH ON TAKEOFF)
3	AIR ACCIDENT, FIXED-WING MILITARY, TAKEOFF,OTHER (INC TAXI COLLISION)
4	AIR ACCIDENT, FIXED-WING MILITARY, LANDING (INC CRASH ON LANDING)
5	AIR ACCIDENT, FIXED-WING MILITARY, TERM OF FLIGHT NOT AT AIRFIELD
6	AIR ACCIDENT, FIXED-WING MILITARY, RADIATION INJURY & OTHER NUC
9	AIR ACCIDENT, FIXED-WING MILITARY, OTHER INJURY
10	AIR ACCIDENT, ROTARY-WING MILITARY, BOARDING OR ALIGHTING
11	AIR ACCIDENT, ROTARY-WING MILITARY, TAXIING,TAKEOFF,LANDING ON CARRIER
12	AIR ACCIDENT, ROTARY-WING MILITARY, TAXIING (INC COLLISION) & HOVERING
13	AIR ACCIDENT, ROTARY-WING MILITARY, TAKEOFF
14	AIR ACCIDENT, ROTARY-WING MILITARY, LANDING
15	AIR ACCIDENT, ROTARY-WING MILITARY, TERMINATION OF FLIGHT
16	AIR ACCIDENT, ROTARY-WING MILITARY, OTHER
17	AIR ACCIDENT, OTHER MILITARY AIRCRAFT, GLIDER
18	AIR ACCIDENT, OTHER MILITARY AIRCRAFT, LIGHTER-THAN-AIR CRAFT
19	AIR ACCIDENT, OTHER MILITARY AIRCRAFT, PLATFORM OR LIKE AIRCRAFT
20	AIR ACCIDENT, PARACHUTING FROM DAMAGED OR FAILED MILITARY AIRCRAFT
21	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY JET BLAST,PLANE PART
22	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY CHUTE OPEN FAILURE
23	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY OPENING SHOCK
24	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY INITIAL GROUND IMPACT
25	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY DRAGGED AFTER LANDING
26	AIR ACCIDENT, PARACHUTING FROM OK MIL CRAFT, INJ BY OTHER CIRCUMSTANCES
28	MILITARY AIRCRAFT ACCIDENT NOT IN FLIGHT, ON AIRCRAFT CARRIER
29	MILITARY AIRCRAFT ACCIDENT NOT IN FLIGHT, NOT SPEC TO BE ON CARRIER
30	AIR ACCIDENT, FLIGHT IN COMMERCIAL TRANSPORT FIXED-WING OR UNSPEC WING
31	AIR ACCIDENT, FLIGHT IN COMMERCIAL OTHER WING (INC ROTARY)
32	AIR ACCIDENT, FLIGHT IN OTHER & UNSPEC NON-MIL FIXED WING AND UNSPEC WING
33	AIR ACCIDENT, FLIGHT IN OTHER & UNSPEC NON-MIL CRAFT (INC ROTARY WING)
34	AIR ACCIDENT, BOARDING/ALIGHTING FROM COMMERCIAL CRAFT (FIXED-WING/OTHER)
35	AIR ACCIDENT, BOARDING/ALIGHTING FROM OTH NON-MIL CRAFT(FIXED-WING/OTHER)
36	ACCIDENT NOT IN FLIGHT INVOLVING COMMERCIAL AIRCRAFT (FIXED-WING/OTHER)
37	ACCIDENT NOT IN FLIGHT INVOLVING NON-MIL AIRCRAFT (FIXED-WING/OTHER)
39	ACCIDENT NOT IN FLIGHT INVOLVING UNSPECIFIED NON MILITARY AIRCRAFT
40	ASTRONAUT IN SPACECRAFT INJURED BY BLAST-OFF ACCIDENT - NO ESCAPE
41	ASTRONAUT IN SPACECRAFT INJURED BY BLAST-OFF ACCIDENT - EJECTED
42	ASTRONAUT IN SPACECRAFT INJURED DURING ASCENT
43	ASTRONAUT IN SPACECRAFT INJURED WHILE IN ORBIT
44	ASTRONAUT IN SPACECRAFT INJURED DURING RE-ENTRY
45	ASTRONAUT IN SPACECRAFT INJURED ON IMPACT AFTER RE-ENTRY - NO ESCAPE
46	ASTRONAUT IN SPACECRAFT INJURED ON IMPACT AFTER RE-ENTRY - DID ESCAPE
47	SPACECRAFT ACCIDENT NOT IN FLIGHT - FUEL HANDLING INVOLVING GROUND CREW
48	SPACECRAFT ACCIDENT NOT IN FLIGHT - EXPLOSION INVOLVING GROUND CREW
49	SPACECRAFT ACCIDENT NOT IN FLIGHT - OTHER OR UNSPECIFIED ACCIDENT
51	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM ACCELERATIVE FORCES ON FIRING
52	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM IMPACT WITH PARTS OF CRAFT
53	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM WINDBLAST
54	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM FALL
55	ESCAPE INJURY, AIR OR SPACECRAFT CREW, IMPACT ON LANDING (LAND OR WATER)
56	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM UNDERWATER EJECTION
57	ESCAPE INJURY, AIR OR SPACECRAFT CREW, FROM OTHER UNSPEC CIRCUMSTANCES
100	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO DRIVER (EXCEPT 106,107)
101	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO PASSENGER (EXCEPT 106,107)

CAUSE OF INJURY CODE	DESCRIPTION
102	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO UNSPECIFIED OCCUPANT
103	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY IN BOARDING/ALIGHTING
104	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO PEDESTRIAN
105	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO PEDAL CYCLIST (DRIVER/RIDER)
106	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJURY TO MOTORCYCLIST (DRIVER/RIDER)
107	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJ OCCUPANT TRACKED/SEMI-TRACKED VEH
109	MOTOR VEH ACCIDENT, NOT MIL OWNED, INJ TO OTHER/UNSPECIFIED PERSON
110	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO DRIVER (EXCEPT 116,117)
111	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO PASSENGER (EXCEPT 116,117)
112	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO UNSPECIFIED OCCUPANT
113	MOTOR VEH ACCIDENT, MIL OWNED, INJURY BOARDING/ALLIGHTING VEHICLE
114	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO PEDESTRIAN
115	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO PEDAL CYCLIST (DRIVER/RIDER)
116	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO MOTORCYCLIST (DRIVER/RIDER)
117	MOTOR VEH ACCIDENT, MIL OWNED, INJ OCCUPANT TRACKED/SEMI-TRACKED VEHICLE
119	MOTOR VEH ACCIDENT, MIL OWNED, INJURY TO OTHER UNSPECIFIED PERSON
120	MOTOR VEH ACCIDENT, INVOLVING NON MILITARY OWNED VEHICLE
130	MOTOR VEH ACCIDENT, NON TRAFFIC, INVOLVING MILITARY OWNED VEHICLE
140	LAND TRANSPORT ACCIDENT - RAILWAY ACCIDENT
149	LAND TRANSPORT ACCIDENT - OTHER SPECIFIED ACCIDENT
150	WATER ACCIDENT, SUBMERSION IN BOARDING AND ALIGHTING
151	WATER ACCIDENT, SUBMERSION OF OCCUPANT OF SMALL BOAT
159	WATER ACCIDENT, OTHER SUBMERSION
160	WATER ACCIDENT, FALL IN BOARDING OR ALIGHTING
161	WATER ACCIDENT, TWIST,TURN,SLIP,RUN (NO FALL) IN BOARDING/ALIGHTING
162	WATER ACCIDENT, FALL ONE LEVEL TO ANOTHER, NOT IN BOARDING/ALIGHTING
163	WATER ACCIDENT, FALL SAME LEVEL, NOT BOARDING/ALIGHTING
164	WATER ACCIDENT, TWIST,TURN,SLIP,RUN (NO FALL) NOT BOARDING/ALIGHTING
170	WATER ACCIDENT INV MACHINERY, BOILERS AND GAUGES IN ENGINE ROOM
171	WATER ACCIDENT INVOLVING OTHER MACHINERY IN ENGINE ROOM
172	WATER ACCIDENT INVOLVING OTHER MACHINERY
190	OTHER WATER ACCIDENT, BOARDING/ALIGHTING EXCLUDES SUBMERSION & FALLS
191	OTHER WATER ACCIDENT, NOXIOUS FUMES (INCLUDES CARBON MONOXIDE)
192	OTHER WATER ACCIDENT, EXCESSIVE HEAT IN ENGINE ROOM, BOILER ROOM, ETC.
193	OTHER WATER ACCIDENT, INADEQUATE VENTILATION INCLUDES OXYGEN DEFICIENCY
194	OTHER WATER ACCIDENT, EFFECTS OF ROUGH WEATHER NEC (EXC SEASICKNESS-871)
195	OTHER WATER ACCIDENT, DIVING ACCIDENT
196	OTHER WATER ACCIDENT, WATERTIGHT DOORS AND HATCH COVERS
197	OTHER WATER ACCIDENT, RADIATION INJURY OR OTHER NUCLEAR
199	OTHER WATER ACCIDENT, OTHER NAUTICAL HAZARD
201	ATHLETIC ACCIDENT ON BOARD SHIP, BASKETBALL
203	ATHLETIC ACCIDENT ON BOARD SHIP, BOXING
204	ATHLETIC ACCIDENT ON BOARD SHIP, CALISTHENICS/GYMNASTICS ("PT")
207	ATHLETIC ACCIDENT ON BOARD SHIP, HANDBALL, FIVES, SQUASH, JAI ALAI
212	ATHLETIC ACCIDENT ON BOARD SHIP, SOFTBALL AND ROUNDERS
213	ATHLETIC ACCIDENT ON BOARD SHIP, SWIMMING AND DIVING
214	ATHLETIC ACCIDENT ON BOARD SHIP, TENNIS AND BADMINTON
216	ATHLETIC ACCIDENT ON BOARD SHIP, WRESTLING, JUDO
219	ATHLETIC ACCIDENT ON BOARD SHIP, OTHER ATHLETICS AND SPORTS
220	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, BASEBALL
221	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, BASKETBALL
222	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, BOATING (SAIL,POWER & OTHER SMALL)
223	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, BOXING
224	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, CALISTHENICS/GYMNASTICS ("PT")
225	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, CRICKET

CAUSE OF INJURY CODE	DESCRIPTION
226	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, FOOTBALL (AMERICAN)
227	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, HANDBALL,FIVES,SQUASH,JAI ALAI
228	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, HOCKEY
229	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, MOUNTAINEERING, SKIING, TOBAGGANING
230	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, RUGGER
231	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, SOCCER AND FOOTBALL UNSPECIFIED
232	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, SOFTBALL AND ROUNDERS
233	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, SWIMMING & DIVING INC WATER POLO
234	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, TENNIS AND BADMINTON
235	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, TRACK AND FIELD EVENTS
236	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, WRESTLING,JUDO,UNARMED COMBAT TRNG
237	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, HORSEMANSHIP
239	ATHLETIC ACCIDENT OTHER/UNSPEC PLACE, OTHER ATHLETICS (EXC OBSTACLE CRSE)
250	COMPLICATIONS OF PROPHYLACTIC INOCULATION, POSTVACCINAL ENCEPHALITIS
251	COMPLICATIONS OF PROPHYLACTIC INOCULATION,SMALLPOX VAC REACT (NOT ENCPH)
252	COMPLICATIONS OF PROPHYLACTIC INOCULATION, TYPHOID/PARATYPHOID VACCINE
253	COMPLICATIONS OF PROPHYLACTIC INOCULATION, TETANUS TOXIN-ANTITOXIN
254	COMPLICATIONS OF PROPHYLACTIC INOCULATION, TETANUS TOXIOD
255	COMPLICATIONS OF PROPHYLACTIC INOCULATION,DIPHTHERIA ANTITOXIN/TOXIOD
256	COMPLICATIONS OF PROPHYLACTIC INOCULATION, BCG
257	COMPLICATIONS OF PROPHYLACTIC INOCULATION, PROPHYL. USE OF ANTIBIOTICS
265	COMPLICATIONS OF PROPHYLACTIC INOCULATION,OTHER SPECIFIED VACCINE
266	COMPLICATION OF PROPHYLACTIC INOCULATION, OTHER SPEC TOXOID/ANTITOXIN
267	COMPLICATIONS OF PROPHYLACTIC INOCULATION,UNSPEC VACCINE,TOXOID,ANTITOXIN
268	COMPLICATIONS OF PROPHYLACTIC INOCULATION,COMB OF TWO/MORE ABOVE
269	COMPLICATIONS OF PROPHYLACTIC INOCULATION,OTHER BIOL SUB INC IMMUNE SERUM
273	COMPLICATIONS, ANESTHESIA WITH DIAGNOSTIC/OTHER NONTHERAPEUTIC PROCEDURES
274	COMPLICATIONS, SURGICAL PROCEDURES (EXCEPT IN THERAPY) INCLUDES COSMETIC
275	COMPLICATIONS, DIAGNOSTIC USE OF X-RAY OR RADIOACTIVE ISOTOPES
276	COMPLICATIONS, DIAGNOSTIC SPINAL TAP
279	COMPLICATIONS, OTHER NONTHERAPEUTIC TEST OR PROCEDURE
280	COMPLICATIONS, TRANSFUSION/INFUSION BLOOD,BLOOD SERUM,PLASMA,PLASMA SUB
281	COMPLICATIONS,THERAPEUTIC ADMINISTRATION OF ANTIBIOTICS
282	COMPLICATIONS, THERAPEUTIC ADMINISTRATION OF OTHER DRUGS OR BIOLOGICALS
283	COMPLICATIONS, ANESTHESIA IN CONNECTION WITH THERAPEUTIC PROCEDURES
284	COMPLICATIONS, SURGICAL TREATMENT
285	COMPLICATIONS, TREATMENT BY X-RAY, RADIUM OR RADIOACTIVE ISOTOPES
286	COMPLICATIONS, THERAPEUTIC SPINAL TAP
287	COMPLICATIONS, OTHER SPECIFIED THERAPY
289	COMPLICATIONS, UNSPECIFIED THERAPY
299	LATE COMPLICTIONS OR LATE EFFECTS OF OLD INJURIES
300	INJURIES, BLAST OF NUCLEAR EXPLOSION, DIRECT EFFECTS
301	INJURIES, HEAT FROM NUCLEAR EXPLOSION (INC FIREBALL), DIRECT EFFECTS
302	INJURIES, EXPOSURE TO PROMPT IONIZING RADIATION
303	INJURIES, SECONDARY MISSILE FROM NUCLEAR EXPLOSION (FALLING WALL, ETC)
304	INURIES, FIRE SECONDRY TO NUCLEAR EXPLOSION
305	INJURIES, OTHER SPECIFIED SECONDRY EFFECT AT TIME OF NUCLEAR EXPLOSION
309	INJURIES, UNSPECIFIED DIRECT EFFECTS OF NUCLEAR EXPLOSION
310	SUBSEQUENT INJURIES, EXPOSURE TO RESIDUAL RADIATION
311	SUBSEQUENT INJURY, INGESTION/INHALATION OF RADIOACTIVE PRODUCTS NUC EXPL
320	AGENTS OF CHEM WARFARE, LUNG IRRITANTS AND IRRITANT SMOKE
321	AGENTS OF CHEM WARFARE, VESICANTS (INCLUDING MUSTARD GAS)
322	AGENTS OF CHEM WARFARE, NERVE GASES
330	AGENTS OF CHEM WARFARE, LACRIMATORS AND SCREENING SMOKES
339	AGENTS OF CHEM WARFARE, OTHER CHEMICAL WARFARE AGENTS (EXC INCENDIARIES)

CAUSE OF INJURY CODE	DESCRIPTION
359	BIOLOGICAL WARFARE AGENTS
400	AIRCRAFT INJURY, ARTILLERY SHELL
401	AIRCRAFT INJURY, ROCKET
402	AIRCRAFT INJURY, BALLISTIC MISSILE
409	AIRCRAFT INJURY, SHELL FRAGMENT OTHERWISE UNSPECIFIED
410	AIRCRAFT INJURY, BULLET, NONEXPLOSIVE NONINCENDIARY, OR UNSPECIFIED
411	AIRCRAFT INJURY, BULLET, EXPLOSIVE
412	AIRCRAFT INJURY, BULLET, INCENDIARY
418	AIRCRAFT INJURY, OTHER SPECIFIED CONVENTIONAL WEAPON
419	AIRCRAFT INJURY, UNSPECIFIED WEAPON, PRESUMABLY CONVENTIONAL
420	INJURY ON BOARD SHIP BY ARTILLERY SHELL
421	INJURY ON BOARD SHIP BY ROCKET
422	INJURY ON BOARD SHIP BY BALLISTIC MISSILE
423	INJURY ON BOARD SHIP BY BOMB, FREE-FALLING
426	INJURY ON BOARD SHIP BY CONTACT MINE OR TORPEDO
427	INJURY ON BOARD SHIP BY UNDERWATER BLAST
429	INJURY ON BOARD SHIP BY SHELL FRAGMENT, OTHER AND UNSPECIFIED
430	INJURY ON BOARD SHIP, BULLET, NONEXPLOSIVE, NONINCENDIARY OR UNSPECIFIED
431	INJURY ON BOARD SHIP, BULLET, EXPLOSIVE
432	INJURY ON BOARD SHIP, BULLET, INCENDIARY
438	INJURY ON BOARD SHIP, OTHER SPECIFIED CONVENTIONAL WEAPON
439	INJURY ON BOARD SHIP, UNSPECIFIED WEAPON, PRESUMABLY CONVENTIONAL
440	PERSONAL INJURY ON LAND/UNSPEC BY ARTILLERY SHELL
441	PERSONAL INJURY ON LAND/UNSPEC BY ROCKET
442	PERSONAL INJURY ON LAND/UNSPEC BY BALLISTIC MISSLE
443	PERSONAL INJURY ON LAND/UNSPEC BY BOMB, FREE-FALLING
444	PERSONAL INJURY ON LAND/UNSPEC BY MORTAR
445	PERSONAL INJURY ON LAND/UNSPEC BY BAZOOKA
446	PERSONAL INJURY ON LAND/UNSPEC BY ANTIPERSONNEL MINE, BOOBY-TRAP, ETC.
447	PERSONAL INJURY ON LAND/UNSPEC BY MINE, OTHER OR UNSPECIFIED
448	PERSONAL INJURY ON LAND/UNSPEC BY GRENADE
449	PERSONAL INJURY ON LAND/UNSPEC BY SHELL FRAGMENT, OTHER AND UNSPECIFIED
450	PERSONAL INJURY ON LAND/UNSPEC BY BULLET, NON-EXPLOSIVE/INCENDIARY,UNSPEC
451	PERSONAL INJURY ON LAND/UNSPEC BY BULLET, EXPLOSIVE
452	PERSONAL INJURY ON LAND/UNSPEC BY BULLET, INCENDIARY
453	PERSONAL INJURY ON LAND/UNSPEC BY FLAME THROWER
454	PERSONAL INJURY ON LAND/UNSPEC BY OTHER INCENDIARIES
455	PERSONAL INJURY ON LAND/UNSPEC BY BAYONET, ETC.
458	PERSONAL INJURY ON LAND/UNSPEC BY OTHER SPECIFIED CONVENTIONAL WEAPON
459	PERSONAL INJURY ON LAND/UNSPEC BY UNSPEC/PRESUMABLY CONVENTIONAL WEAPON
460	INDIRECT/SECONDARY EFFECTS IN WARTIME, AIRCRAFT CRASH OR DESTRUCTION
461	INDIRECT/SECONDARY EFFECTS IN WARTIME, SINKING OF VESSEL
462	INDIRECT/SECONDARY EFFECTS IN WARTIME, FIRE ON AIRCRAFT
463	INDIRECT/SECONDARY EFFECTS IN WARTIME, FIRE ON SHIP
464	INDIRECT/SECONDARY EFFECTS IN WARTIME, FIRE ON LAND
465	INDIRECT/SECONDARY EFFECTS IN WARTIME, EXPLOSION ON AIRCRAFT
466	INDIRECT/SECONDARY EFFECTS IN WARTIME, EXPLOSION ON SHIP
467	INDIRECT/SECONDARY EFFECTS IN WARTIME, EXPLOSION ON LAND
477	INDIRECT/SECONDARY EFFECTS IN WARTIME, OTHER IN AIRCRAFT
478	INDIRECT/SECONDARY EFFECTS IN WARTIME, OTHER ON SHIP
479	INDIRECT/SECONDARY EFFECTS IN WARTIME, OTHER ON LAND
480	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, OWN NUCLEAR WEAPONS
481	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, OWN CHEMICAL WARFARE AGENTS
482	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, BIOLOGICAL WARFARE AGENTS
486	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, ROCKETS, MISSLES, ETC.

CAUSE OF INJURY CODE	DESCRIPTION
487	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, LAUNCHING MECHS
488	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, OWN BOMBS, ARTILLERY/ETC
489	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, MECHS OF ARTILLERY/ETC
490	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, MINES, TORPEDOS, ETC.
491	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, OWN SMALL ARM FIRE
492	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, EXPLOSION OF MUNITIONS
493	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, EXPLOSION OF OWN WEAPONS
494	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, EFFECTS OF WEAPON DISCHARGE
495	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, MECHS OF SMALL ARM WEAPONS
496	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, HANDLING WEAPONS/MUNITION
499	ACCIDENTS WITH OWN INSTRUMENTALITIES OF WAR, UNSPEC INJURY IN WARTIME
500	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON IN AIR,SPACE(CRAFT)
501	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON SHIP, IN/ON WATER
502	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON LAND, AT AIRFIELD
503	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON LAND, AT DOCK
504	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON AT INDUSTRIAL PLANT
505	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON RANGE, DRILLFIELD
506	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON ON OBSTACLE COURSE
507	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON IN KITCHEN, MESS
508	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON, IN HOME, QTRS,ETC
509	INJURY NOT INSTRUMENTALITY OF WAR BY NUCLEAR WEAPON, ON LAND OTH/UNSPEC
510	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE IN AIR,SPACE(CRAFT)
511	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE ON SHIP,IN/ON WATER
512	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE, AT AIRFIELD
513	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE, AT DOCK
514	INJURY NOT INSTRUMENTALITY OF WAR BY CHEMICAL WARFARE, AT INDUSTRIAL PLT
515	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, ON RANGE, DRILLFIELD
516	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, ON OBSTACLE COURSE
517	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, IN KITCHEN, MESS
518	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, IN HOME, QTRS
519	INJURY NOT INSTRUMENTALITY OF WAR BY CHEM WARFARE, ON LAND OTH/UNSPEC
520	INJURY NOT INSTRUMENTALITY OF WAR BY BIOLOGICAL AGENT IN AIR,SPACE(CRAFT)
521	INJURY NOT INSTRUMENTALITY OF WAR BY BIOLOGICAL AGENT ON SHIP,IN/ON WATER
522	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, AT AIRFIELD
523	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, AT DOCK
524	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, AT INDUSTRIAL PLANT
525	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, RANGE, DRILLFIELD
526	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, ON OBSTACLE COURSE
527	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, IN KITCHEN, MESS
528	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, IN HOME, QTRS
529	INJURY NOT INSTRUMENTALITY OF WAR BY BIO AGENT, ON LAND OTHER/UNSPEC
530	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSILE IN AIR/SPACE(CRAFT)
531	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSLE, ON SHIP IN/ON WATER
532	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSLE, AT AIRFIELD
533	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSLE, AT DOCK
534	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSLE, AT INDUSTRIAL PLANT
535	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSLE, ON RANGE, DRILLFIELD
536	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSLE, ON OBSTACLE COURSE
537	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSLE, IN KITCHEN, MESS
538	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSLE, IN HOME, QTRS
539	INJURY NOT INSTRUMENTALITY OF WAR BY ROCKET/MISSLE, ON LAND OTHER/UNSPEC
540	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, AIR,SPACE(CRAFT)
541	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, SHIP IN/ON WATER
542	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, AT AIRFIELD
543	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, AT DOCK

CAUSE OF INJURY CODE	DESCRIPTION
544	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, AT INDUSTRIAL PLT
545	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECT, RANGE, DRILLFIELD
546	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, ON OBSTACLE CRS
547	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, IN KITCHEN, MESS
548	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECT, IN HOME, QTRS
549	INJURY NOT INSTRUMENTALITY OF WAR BY BOMBS/PROJECTILES, ON LAND OTH/UNSP
550	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, IN AIR/SPACE(CRAFT)
551	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, SHIP, IN/OUT WATER
552	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, AT AIRFIELD
553	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, AT DOCK
554	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, AT INDUSTRIAL PLANT
555	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, ON RANGE, DRILLFIELD
556	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, ON OBSTACLE COURSE
557	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, KITCHEN, MESS
558	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, IN HOME, QTRS
559	INJURY NOT INSTRUMENTALITY OF WAR BY MINES, ON LAND OTHER/UNSPEC
560	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, IN AIR,SPACE(CRAFT)
561	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, SHIP,IN/ON WATER
562	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, AT AIRFIELD
563	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, AT DOCK
564	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, AT INDUSTRIAL PLANT
565	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, RANGE, DRILLFIELD
566	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, ON OBSTACLE CRS
567	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, IN KITCHEN, MESS
568	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, IN HOME, QTRS
569	INJURY NOT INSTRUMENTALITY OF WAR BY SMALL ARMS FIRE, ON LAND OTH/UNSP
570	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, IN AIR/SPACE(CRAFT)
571	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, SHIP IN/ON WATER
572	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, AT AIRFEILD
573	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, AT DOCK
574	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, AT INDUSTRIAL PLANT
575	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, RANGE, DRILLFIELD
576	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, ON OBSTACLE COURSE
577	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, IN KITCHEN, MESS
578	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, IN HOME, QTRS
579	INJURY NOT INSTRUMENTALITY/WAR EXPL W/HANDLING AMMO, ON LAND/OTHER/UNSPEC
580	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, IN AIR/SPACE(CRAFT)
581	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, SHIP, IN/ON WATER
582	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, AT AIRFIELD
583	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, AT DOCK
584	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, AT INDUSTRIAL PLANT
585	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, ON RANGE, DRILLFLD
586	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, ON OBSTACLE CRS
587	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, IN KITCHEN, MESS
588	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, IN HOME, QTRS
589	INJURY NOT INSTRUMENTALITY OF WAR MECH OF SMALL ARMS, ON LAND/OTH/UNSP
590	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, IN AIR,SPACE(CRAFT)
591	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, SHIP,IN/ON WATER
592	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, AT AIRFIELD
593	INJURY NOT INSTRUMENTALTIY OF WAR OTH GUN/EXPLOSIVE, AT DOCK
594	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, AT INDUSTRIAL PLANT
595	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, ON RANGE,DRILLFIELD
596	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, ON OBSTACLE COURSE
597	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, IN KITCHEN, MESS
598	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, IN HOME, QTRS

CAUSE OF INJURY CODE	DESCRIPTION
599	INJURY NOT INSTRUMENTALITY OF WAR OTH GUN/EXPLOSIVE, ON LAND/OTH/UNSPEC
600	MACHINERY (INC CRANES OR ELEVATORS) IN AIR,SPACE(CRAFT)
601	MACHINERY (INC CRANES OR ELEVATORS) ON SHIP, IN/ON WATER
602	MACHINERY (INC CRANES OR ELEVATORS) AT AIRFIELD
603	MACHINERY (INC CRANES OR ELEVATORS) AT DOCK
604	MACHINERY (INC CRANES OR ELEVATORS) AT INDUSTRIAL PLANT
605	MACHINERY (INC CRANES OR ELEVATORS) AT RANGE, DRILLFIELD
606	MACHINERY (INC CRANES OR ELEVATORS) ON OBSTACLE COURSE
607	MACHINERY (INC CRANES OR ELEVATORS) IN KITCHEN, MESS
608	MACHINERY (INC CRANES OR ELEVATORS) IN HOME, QTRS
609	MACHINERY (INC CRANES OR ELEVATORS) ON LAND, OTHER/UNSPECIFIED
610	TOOLS, POWER/HAND (EXC KNIVES) IN AIR, SPACE(CRAFT)
611	TOOLS, POWER/HAND (EXC KNIVES) ON SHIP IN/ON WATER
612	TOOLS, POWER/HAND (EXC KNIVES) AT AIRFIELD
613	TOOLS, POWER/HAND (EXC KNIVES) AT DOCK
614	TOOLS, POWER/HAND (EXC KNIVES) AT INDUSTRIAL PLANT
615	TOOLS, POWER/HAND (EXC KNIVES) AT RANGE, DRILLFIELD
616	TOOLS, POWER/HAND (EXC KNIVES) ON OBSTACLE COURSE
617	TOOLS, POWER/HAND (EXC KNIVES) IN KITCHEN, MESS
618	TOOLS, POWER/HAND (EXC KNIVES) IN HOME, QTRS
619	TOOLS, POWER/HAND (EXC KNIVES) ON LAND, OTHER/UNSPECIFIED
620	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) IN AIR, SPACE(CRAFT)
621	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) ON SHIP, IN/OUT WATER
622	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) AT AIRFIELD
623	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) AT DOCK
624	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) AT INDUSTRIAL PLANT
625	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) ON RANGE, DRILLFIELD
626	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) ON OBSTACLE COURSE
627	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) IN KITCHEN, MESS
628	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) IN HOME, QTRS
629	ELECTRIC CURRENT (EXC LIGHTNING/ELEC HEAT) ON LAND, OTHER/UNSPECIFIED
630	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) IN AIR,SPACE(CRAFT)
631	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) ON SHIP, IN/ON WATER
632	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) AT AIRFIELD
633	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) AT DOCK
634	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) AT INDUSTRIAL PLANT
635	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) ON RANGE, DRILLFIELD
636	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) ON OBSTACLE COURSE
637	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) IN KITCHEN, MESS
638	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) AT HOME, QTRS
639	XRAY, OTH RADIOACTIVE SUBSTANCE (EXC THERAPY/NUCS) ON LAND, OTH/UNSPEC
640	CUTTING, PIERCING INSTRUMENTS/OBJECTS IN AIR, SPACE(CRAFT)
641	CUTTING, PIERCING INSTRUMENTS/OBJECTS ON SHIP, IN/ON WATER
642	CUTTING, PIERCING INSTRUMENTS/OBJECTS AT AIRFIELD
643	CUTTING, PIERCING INSTRUMENTS/OBJECTS AT DOCK
644	CUTTING, PIERCING INSTRUMENTS/OBJECTS AT INDUSTRIAL PLANT
645	CUTTING, PIERCING INSTRUMENTS/OBJECTS ON RANGE, DRILLFIELD
646	CUTTING, PIERCING INSTRUMENTS/OBJECTS ON OBSTACLE COURSE
647	CUTTING, PIERCING INSTRUMENTS/OBJECTS IN KITCHEN, MESS
648	CUTTING, PIERCING INSTRUMENTS/OBJECTS IN HOME, QTRS
649	CUTTING, PIERCING INSTRUMENTS/OBJECTS ON LAND, OTHER/UNSPECIFIED
650	EXPLOSION OF PRESSURE VESSEL, NO FIRE IN AIR, SPACE(CRAFT)
651	EXPLOSION OF PRESSURE VESSEL, NO FIRE ON SHIP, IN/ON WATER
652	EXPLOSION OF PRESSURE VESSEL, NO FIRE AT AIRFIELD
653	EXPLOSION OF PRESSURE VESSEL, NO FIRE AT DOCK

CAUSE OF INJURY CODE	DESCRIPTION
654	EXPLOSION OF PRESSURE VESSEL, NO FIRE AT INDUSTRIAL PLANT
655	EXPLOSION OF PRESSURE VESSEL, NO FIRE ON RANGE, DRILLFIELD
656	EXPLOSION OF PRESSURE VESSEL, NO FIRE ON OBSTACLE COURSE
657	EXPLOSION OF PRESSURE VESSEL, NO FIRE IN KITCHEN, MESS
658	EXPLOSION OF PERSSURE VESSEL, NO FIRE IN HOME, QTRS
659	EXPLOSION OF PRESSURE VESSEL, NO FIRE ON LAND, OTHER/UNSPECIFIED
660	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) IN AIR, SPACE(CRAFT)
661	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) ON SHIP, IN/ON WATER
662	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) AT AIRFIELD
663	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) AT DOCK
664	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) AT INDUSTRIAL PLANT
665	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) ON RANGE, DRILLFIELD
666	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) ON OBSTACLE COURSE
667	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) IN KITCHEN, MESS
668	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) IN HOME, QTRS
669	FALLING/PROJECTED OBJECT OR MISSLE (EXC BULLETS ETC) ON LAND, OTH/UNSPEC
670	STATIC OBJECTS (INC "BUMPING AGAINST") IN AIR, SPACE(CRAFT)
671	STATIC OBJECTS (INC "BUMPING AGAINST") ON SHIP, IN/ON WATER
672	STATIC OBJECTS (INC "BUMPING AGAINST") AT AIRFIELD
673	STATIC OBJECTS (INC "BUMPING AGAINST") AT DOCK
674	STATIC OBJECTS (INC "BUMPING AGAINST") AT INDUSTRIAL PLANT
675	STATIC OBJECTS (INC "BUMPING AGAINST") ON RANGE, DRILLFIELD
676	STATIC OBJECTS (INC "BUMPING AGAINST") ON OBSTACLE COURSE
677	STATIC OBJECTS (INC "BUMPING AGAINST") IN KITCHEN, MESS
678	STATIC OBJECTS (INC "BUMPING AGAINST") IN HOME, QTRS
679	STATIC OBJECTS (INC "BUMPING AGAINST") ON LAND, OTHER/UNSPECIFIED
680	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) IN AIR, SPACE(CRAFT)
681	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) ON SHIP, IN/ON WATER
682	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) AT AIRFIELD
683	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) AT DOCK
684	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) AT INDUSTRIAL PLANT
685	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) ON RANGE, DRILLFIELD
686	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) ON OBSTACLE COURSE
687	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) IN KITCHEN, MESS
688	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) IN HOME, QTRS
689	FORIEGN OBJECT ENTERING BODY (IN EYE, ETC) ON LAND, OTHER/UNSPECIFIED
690	SHOES, CLOTHING, ETC. IN AIR, SPACE(CRAFT)
691	SHOES, CLOTHING, ETC. ON SHIP IN/ON WATER
692	SHOES, CLOTHING, ETC. AT AIRFIELD
693	SHOES, CLOTHING, ETC. AT DOCK
694	SHOES, CLOTHING, ETC. AT INDUSTRIAL PLANT
695	SHOES, CLOTHING, ETC. ON RANGE, DRILLFIELD
696	SHOES, CLOTHING, ETC. ON OBSTACLE COURSE
697	SHOES, CLOTHING, ETC. IN KITCHEN, MESS
698	SHOES, CLOTHING, ETC. IN HOME, QTRS
699	SHOES, CLOTHING, ETC. ON LAND, OTHER/UNSPECIFIED
700	POISONING BY INGESTION OF TOXIC SUBSTANCE IN AIR, SPACE(CRAFT)
701	POISONING BY INGESTION OF TOXIC SUBSTANCE ON SHIP, IN/ON WATER
702	POISONING BY INGESTION OF TOXIC SUBSTANCE AT AIRFIELD
703	POISONING BY INGESTION OF TOXIC SUBSTANCE AT DOCK
704	POISONING BY INGESTION OF TOXIC SUBSTANCE AT INDUSTRIAL PLANT
705	POISONING BY INGESTION OF TOXIC SUBSTANCE ON RANGE, DRILLFIELD
706	POISONING BY INGESTION OF TOXIC SUBSTANCE ON OBSTACLE COURSE
707	POISONING BY INGESTION OF TOXIC SUBSTANCE IN KITCHEN, MESS
708	POISONING BY INGESTION OF TOXIC SUBSTANCE IN HOME, QTRS

CAUSE OF INJURY CODE	DESCRIPTION
709	POISONING BY INGESTION OF TOXIC SUBSTANCE ON LAND, OTHER/UNSPECIFIED
710	POISONING BY INHALATION OF TOXIC SUBSTANCE IN AIR, SPACE(CRAFT)
711	POISONING BY INHALATION OF TOXIC SUBSTANCE ON SHIP, IN/ON WATER
712	POISONING BY INHALATION OF TOXIC SUBSTANCE AT AIRFIELD
713	POISONING BY INHALATION OF TOXIC SUBSTANCE AT DOCK
714	POISONING BY INHALATION OF TOXIC SUBSTANCE AT INDUSTRIAL PLANT
715	POISONING BY INHALATION OF TOXIC SUBSTANCE ON RANGE, DRILLFIELD
716	POISONING BY INHALATION OF TOXIC SUBSTANCE ON OBASTACLE COURSE
717	POISONING BY INHALATION OF TOXIC SUBSTANCE IN KITCHEN, MESS
718	POISONING BY INHALATION OF TOXIC SUBSTANCE IN HOME, QTRS
719	POISONING BY INHALATION OF TOXIC SUBSTANCE ON LAND, OTHER/UNSPECIFIED
720	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE IN AIR, SPACE(CRAFT)
721	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE ON SHIP, IN/ON WATER
722	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE AT AIRFIELD
723	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE AT DOCK
724	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE AT INDUSTRIAL PLANT
725	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE ON RANGE, DRILLFIELD
726	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE ON OBSTACLE COURSE
727	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE IN KITCHEN, MESS
728	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE IN HOME, QTRS
729	ADVERSE SYSTEMIC OR SKIN REACTION/TOXIC SUBSTANCE ON LAND, OTH/UNSPEC
730	STING OR BITE OF VENOMOUS REPTILE IN AIR, SPACE(CRAFT)
731	STING OR BITE OF VENOMOUS REPTILE ON SHIP, IN/ON WATER
732	STING OR BITE OF VENOMOUS REPTILE AT AIRFIELD
733	STING OR BITE OF VENOMOUS REPTILE AT DOCK
734	STING OR BITE OF VENOMOUS REPTILE AT INDUSTRIAL PLANT
735	STING OR BITE OF VENOMOUS REPTILE ON RANGE OR DILLFIELD
736	STING OR BITE OF VENOMOUS REPTILE ON OBSTACLE COURSE
737	STING OR BITE OF VENOMOUS REPTILE IN KITCHEN, MESS
738	STING OR BITE OF VENOMOUS REPTILE IN HOME, QTRS
739	STING OR BITE OF VENOMOUS REPTILE ON LAND, OTHER/UNSPECIFIED
740	STING OR BITE OF VENOMOUS ARTHROPOD IN AIR, SPACE(CRAFT)
741	STING OR BITE OF VENOMOUS ARTHROPOD ON SHIP, IN/ON WATER
742	STING OR BITE OF VENOMOUS ARTHROPOD AT AIRFIELD
743	STING OR BITE OF VENOMOUS ARTHROPOD AT DOCK
744	STING OR BITE OF VENOMOUS ARTHROPOD AT INDUSTRIAL PLANT
745	STING OR BITE OF VENOMOUS ARTHROPOD ON RANGE, DRILLFIELD
746	STING OR BITE OF VENOMOUS ARTHROPOD ON OBSTACLE COURSE
747	STING OR BITE OF VENOMOUS ARTHROPOD IN KITCHEN, MESS
748	STING OR BITE OF VENOMOUS ARTHROPOD IN HOME, QTRS
749	STING OR BITE OF VENOMOUS ARTHROPOD ON LAND, OTHER/UNSPECIFIED
750	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION IN AIR, SPACE(CRAFT)
751	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION ON SHIP, IN/ON WATER
752	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION AT AIRFIELD
753	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION AT DOCK
754	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION AT INDUSTRIAL PLANT
755	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION ON RANGE, DRILLFIELD
756	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION ON OBSTACLE COURSE
757	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION IN KITCHEN, MESS
758	FIRE, EXPLOSION WITH FIRE, CONFLAGRATION IN HOME, QTRS
759	FIRE, EXPLSION WITH FIRE, CONFLAGRATION ON LAND, OTHER/UNSPECIFIED
760	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) IN AIR, SPACE(CRAFT)
761	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) ON SHIP, IN/ON WATER
762	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) AT AIRFIELD
763	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) AT DOCK

CAUSE OF INJURY CODE	DESCRIPTION
764	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) AT INDUSTRIAL
765	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) ON RANGE, DRILLFIELD
766	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) ON OBSTACLE COURSE
767	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) IN KITCHEN, MESS
768	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) IN HOME, QTRS
769	HOT LIQUIDS OR STEAM (INC MOLTEN METAL) ON LAND, OTHER/UNSPECIFIED
770	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, IN AIR, SPACE(CRAFT)
771	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, ON SHIP, IN/ON WATER
772	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, AT AIRFIELD
773	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, AT DOCK
774	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, AT INDUSTRIAL PLANT
775	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, ON RANGE, DRILLFIELD
776	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, ON OBSTACLE COURSE
777	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, IN KITCHEN, MESS
778	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, IN HOME, QTRS
779	CORROSIVE SUBSTANCES, EXTERNAL CHEM BURNS ONLY, ON LAND, OTHER/UNSPEC
780	HOT SOLIDS, OTHER HOT OBJECTS IN AIR, SPACE(CRAFT)
781	HOT SOLIDS, OTHER HOT OBJECTS ON SHIP, IN/ON WATER
782	HOT SOLIDS, OTHER HOT OBJECTS AT AIRFIELD
783	HOT SOLIDS, OTHER HOT OBJECTS AT DOCK
784	HOT SOLIDS, OTHER HOT OBJECTS AT INDUSTRIAL PLANT
785	HOT SOLIDS, OTHER HOT OBJECTS ON RANGE, DRILLFIELD
786	HOT SOLIDS, OTHER HOT OBJECTS ON OBSTACLE COURSE
787	HOT SOLIDS, OTHER HOT OBJECTS IN KITCHEN, MESS
788	HOT SOLIDS, OTHER HOT OBJECTS IN HOME, QTRS
789	HOT SOLIDS, OTHER HOT OBJECTS ON LAND, OTHER/UNSPECIFIED
800	EXCESSIVE HEAT OR ISOLATION IN AIR, SPACE(CRAFT)
801	EXCESSIVE HEAT OR ISOLATION ON SHIP, IN/ON WATER
802	EXCESSIVE HEAT OR ISOLATION AT AIRFIELD
803	EXCESSIVE HEAT OR ISOLATION AT DOCK
804	EXCESSIVE HEAT OR ISOLATION AT INDUSTRIAL PLANT
805	EXCESSIVE HEAT OR ISOLATION ON RANGE, DRILLFIELD
806	EXCESSIVE HEAT OR ISOLATION ON OBSTACLE COURSE
807	EXCESSIVE HEAT OR ISOLATION IN KITCHEN, MESS
808	EXCESSIVE HEAT OR ISOLATION IN HOME, QTRS
809	EXCESSIVE HEAT OR ISOLATION ON LAND, OTHER/UNSPECIFIED
810	EXCESSIVE COLD IN AIR, SPACE(CRAFT)
811	EXCESSIVE COLD ON SHIP, IN/ON WATER
812	EXCESSIVE COLD AT AIRFIELD
813	EXCESSIVE COLD AT DOCK
814	EXCESSIVE COLD AT INDUSTRIAL PLANT
815	EXCESSIVE COLD ON RANGE, DRILLFIELD
816	EXCESSIVE COLD ON OBSTACLE COURSE
817	EXCESSIVE COLD IN KITCHEN, MESS
818	EXCESSIVE COLD IN HOME, QTRS
819	EXCESSIVE COLD ON LAND, OTHER/UNSPECIFIED
820	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) IN AIR, SPACE(CRAFT)
821	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) ON SHIP, IN/ON WATER
822	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) AT AIRFIELD
823	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) AT DOCK
824	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) AT INDUSTRIAL PLANT
825	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) ON RANGE, DRILLFIELD
826	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) ON OBSTACLE COURSE
827	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) IN KITCHEN, MESS
828	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) IN HOME, QTRS

CAUSE OF INJURY CODE	DESCRIPTION
829	HIGH/LOW PRESSURE (ATMOSPHERIC OR ARTIFICIAL) ON LAND, OTHER/UNSPECIFIED
830	EXCESSIVE NOISE IN AIR, SPACE(CRAFT)
831	EXCESSIVE NOISE ON SHIP, IN/ON WATER
832	EXCESSIVE NOISE AT AIRFIELD
833	EXCESSIVE NOISE AT DOCK
834	EXCESSIVE NOISE AT INDUSTRIAL PLANT
835	EXCESSIVE NOISE ON RANGE, DRILLFIELD
836	EXCESSIVE NOISE ON OBSTACLE COURSE
837	EXCESSIVE NOISE IN KITCHEN, MESS
838	EXCESSIVE NOISE IN HOME, QTRS
839	EXCESSIVE NOISE ON LAND, OTHER/UNSPECIFIED
840	HUNGER, THIRST, OR EXPOSURE IN AIR, SPACE(CRAFT)
841	HUNGER, THIRST, OR EXPOSURE ON SHIP, IN/ON WATER
842	HUNGER, THIRST, OR EXPOSURE AT AIRFIELD
843	HUNGER, THIRST, OR EXPOSURE AT DOCK
844	HUNGER, THIRST, OR EXPOSURE AT INDUSTRIAL PLANT
845	HUNGER, THIRST, OR EXPOSURE ON RANGE, DRILLFIELD
846	HUNGER, THIRST, OR EXPOSURE ON OBSTACLE COURSE
847	HUNGER, THIRST, OR EXPOSURE IN KITCHEN, MESS
848	HUNGER, THIRST, OR EXPOSURE IN HOME, QTRS
849	HUNGER, THIRST, OR EXPOSURE ON LAND, OTHER/UNSPECIFIED
850	LIGHTNING OR CATACLYSM IN AIR, SPACE(CRAFT)
851	LIGHTNING OR CATACLYSM ON SHIP, IN/ON WATER
852	LIGHTNING OR CATACLYSM AT AIRFIELD
853	LIGHTNING OR CATACLYSM AT DOCK
854	LIGHTNING OR CATACLYSM AT INDUSTRIAL PLANT
855	LIGHTNING OR CATACLYSM ON RANGE, DRILLFIELD
856	LIGHTNING OR CATACLYSM ON OBSTACLE COURSE
857	LIGHTNING OR CATACLYSM IN KITCHEN, MESS
858	LIGHTNING OR CATACLYSM IN HOME, QTRS
859	LIGHTNING OR CATACLYSM ON LAND, OTHER/UNSPECIFIED
860	DROWNING/SUBMERSION N.E.C. IN AIR, SPACE(CRAFT)
861	DROWNING/SUBMERSION N.E.C. ON SHIP, IN/ON WATER
862	DROWNING/SUBMERSION N.E.C. AT AIRFIELD
863	DROWNING/SUBMERSION N.E.C. AT DOCK
864	DROWNING/SUBMERSION N.E.C. AT INDUSTRIAL PLANT
865	DROWNING/SUBMERSION N.E.C. ON RANGE, DRILLFIELD
866	DROWNING/SUBMERSION N.E.C. ON OBSTACLE COURSE
867	DROWNING/SUBMERSION N.E.C. IN KITCHEN, MESS
868	DROWNING/SUBMERSION N.E.C. IN HOME, QTRS
869	DROWNING/SUBMERSION N.E.C. ON LAND, OTHER/UNSPECIFIED
870	MOTION: TRAVEL SICKNESSES IN AIR, SPACE(CRAFT)
871	MOTION: TRAVEL SICKNESSES ON SHIP, IN/ON WATER
872	MOTION: TRAVEL SICKNESSES AT AIRFIELD
873	MOTION: TRAVEL SICKNESSES AT DOCK
874	MOTION: TRAVEL SICKNESSES AT INDUSTRIAL PLANT
875	MOTION: TRAVEL SICKNESSES ON RANGE, DRILLFIELD
876	MOTION: TRAVEL SICKNESSES ON OBSTACLE COURSE
877	MOTION: TRAVEL SICKNESSES IN KITCHEN, MESS
878	MOTION: TRAVEL SICKNESSES IN HOME, QTRS
879	MOTION: TRAVEL SICKNESSES ON LAND, OTHER/UNSPECIFIED
880	ANIMALS, N.E.C. IN AIR, SPACE(CRAFT)
881	ANIMALS, N.E.C. ON SHIP, IN/ON WATER
882	ANIMALS, N.E.C. AT AIRFIELD
883	ANIMALS, N.E.C. AT DOCK

CAUSE OF INJURY CODE	DESCRIPTION
884	ANIMALS, N.E.C. AT INDUSTRIAL PLANT
885	ANIMALS, N.E.C. ON RANGE, DRILLFIELD
886	ANIMALS, N.E.C. ON OBSTACLE COURSE
887	ANIMALS, N.E.C. IN KITCHEN, MESS
888	ANIMALS, N.E.C. IN HOME, QTRS
889	ANIMALS, N.E.C. ON LAND, OTHER/UNSPECIFIED
900	FALL/JUMP FROM STAIRS OR LADDER IN AIR, SPACE(CRAFT)
901	FALL/JUMP FROM STAIRS OR LADDER ON SHIP, IN/ON WATER
902	FALL/JUMP FROM STAIRS OR LADDER AT AIRFIELD
903	FALL/JUMP FROM STAIRS OR LADDER AT DOCK
904	FALL/JUMP FROM STAIRS OR LADDER AT INDUSTRIAL PLANT
905	FALL/JUMP FROM STAIRS OR LADDER ON RANGE, DRILLFIELD
906	FALL/JUMP FROM STAIRS OR LADDER ON OBSTACLE COURSE
907	FALL/JUMP FROM STAIRS OR LADDER IN KITCHEN, MESS
908	FALL/JUMP FROM STAIRS OR LADDER IN HOME, QTRS
909	FALL/JUMP FROM STAIRS OR LADDER ON LAND, OTHER/UNSPECIFIED
910	OTHER FALL/JUMP IN AIR, SPACE(CRAFT)
911	OTHER FALL/JUMP ON SHIP, IN/ON WATER
912	OTHER FALL/JUMP AT AIRFIELD
913	OTHER FALL/JUMP AT DOCK
914	OTHER FALL/JUMP AT INDUSTRIAL PLANT
915	OTHER FALL/JUMP ON RANGE, DRILLFIELD
916	OTHER FALL/JUMP ON OBSTACLE COURSE
917	OTHER FALL/JUMP IN KITCHEN, MESS
918	OTHER FALL/JUMP IN HOME, QTRS
919	OTHER FALL/JUMP ON LAND, OTHER/UNSPECIFIED
920	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) IN AIR, SPACE(CRAFT)
921	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) ON SHIP, IN/ON WATER
922	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) AT AIRFIELD
923	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) AT DOCK
924	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) AT INDUSTRIAL PLANT
925	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) ON RANGE, DRILLFIELD
926	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) ON OBSTACLE COURSE
927	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) IN KITCHEN, MESS
928	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) IN HOME, QTRS
929	FALLS/JUMPS ON SAME LEVEL (INC UNSPEC FALLS) ON LAND, OTHER/UNSPECIFIED
930	MARCHING OR DRILLING N.E.C. IN AIR, SPACE(CRAFT)
931	MARCHING OR DRILLING N.E.C. ON SHIP, IN/ON WATER
932	MARCHING OR DRILLING N.E.C. AT AIRFIELD
933	MARCHING OR DRILLING N.E.C. AT DOCK
934	MARCHING OR DRILLING N.E.C. AT INDUSTRIAL PLANT
935	MARCHING OR DRILLING N.E.C. ON RANGE, DRILLFIELD
936	MARCHING OR DRILLING N.E.C. ON OBSTACLE COURSE
937	MARCHING OR DRILLING N.E.C. IN KITCHEN, MESS
938	MARCHING OR DRILLING N.E.C. IN HOME, QTRS
939	MARCHING OR DRILLING N.E.C. ON LAND, OTHER/UNSPECIFIED
940	TWISTING, TURNING, SLIPPING, ETC, W/O FALL IN AIR, SPACE(CRAFT)
941	TWISTING, TURNING, SLIPPING, ETC W/O FALL ON SHIP, IN/ON WATER
942	TWISTING, TURNING, SLIPPING, ETC W/O FALL AT AIRFIELD
943	TWISTING, TURNING, SLIPPING, ETC W/O FALL AT DOCK
944	TWISTING, TURNING, SLIPPING, ETC W/O FALL AT INDUSTRIAL PLANT
945	TWISTING, TURNING, SLIPPING, ETC W/O FALL ON RANGE, DRILLFIELD
946	TWISTING, TURNING, SLIPPING, ETC W/O FALL ON OBSTACLE COURSE
947	TWISTING, TURNING, SLIPPING, ETC W/O FALL IN KITCHEN, MESS
948	TWISTING, TURNING, SLIPPING, ETC W/O FALL IN HOME, QTRS

CAUSE OF INJURY CODE	DESCRIPTION
949	TWISTING, TURNING, SLIPPING, ETC W/O FALL ON LAND, OTHER/UNSPECIFIED
950	LIFTING, PUSHING, PULLING IN AIR, SPACE(CRAFT)
951	LIFTING, PUSHING, PULLING ON SHIP, IN/ON WATER
952	LIFTING, PUSHING, PULLING AT AIRFIELD
953	LIFTING, PUSHING, PULLING AT DOCK
954	LIFTING, PUSHING, PULLING AT INDUSTRIAL PLANT
955	LIFTING, PUSHING, PULLING ON RANGE, DRILLFIELD
956	LIFTING, PUSHING, PULLING ON OBSTACLE COURSE
957	LIFTING, PUSHING, PULLING IN KITCHEN, MESS
958	LIFTING, PUSHING, PULLING IN HOME, QTRS
959	LIFTING, PUSHING, PULLING ON LAND, OTHER/UNSPECIFIED
960	HANGING, SUFFOCATION, STRANGULATION, ETC IN AIR, SPACE(CRAFT)
961	HANGING, SUFFOCATION, STRANGULATION, ETC ON SHIP, IN/ON WATER
962	HANGING, SUFFOCATION, STRANGULATION, ETC AT AIRFIELD
963	HANGING, SUFFOCATION, STRANGULATION, ETC AT DOCK
964	HANGING, SUFFOCATION, STRANGULATION, ETC AT INDUSTRIAL PLANT
965	HANGING, SUFFOCATION, STRANGULATION, ETC ON RANGE, DRILLFIELD
966	HANGING, SUFFOCATION, STRANGULATION, ETC ON OBSTACLE COURSE
967	HANGING, SUFFOCATION, STRANGULATION, ETC IN KITCHEN, MESS
968	HANGING, SUFFOCATION, STRANGULATION, ETC IN HOME, QTRS
969	HANGING, SUFFOCATION, STRANGULATION, ETC ON LAND, OTHER/UNSPECIFIED
970	FIGHTING N.E.C. IN AIR, SPACE(CRAFT)
971	FIGHTING N.E.C. ON SHIP IN/ON WATER
972	FIGHTING N.E.C. AT AIRFIELD
973	FIGHTING N.E.C. AT DOCK
974	FIGHTING N.E.C. AT INDUSTRIAL PLANT
975	FIGHTING N.E.C. ON RANGE, DRILLFIELD
976	FIGHTING N.E.C. ON OBSTACLE COURSE
977	FIGHTING N.E.C. IN KITCHEN, MESS
978	FIGHTING N.E.C. IN HOME, QTRS
979	FIGHTING N.E.C. ON LAND, OTHER/UNSPECIFIED
980	OTHER SPECIFIED AGENTS N.E.C. IN AIR, SPACE(CRAFT)
981	OTHER SPECIFIED AGENTS N.E.C. ON SHIP, IN/ON WATER
982	OTHER SPECIFIED AGENTS N.E.C. AT AIRFIELD
983	OTHER SPECIFIED AGENTS N.E.C. AT DOCK
984	OTHER SPECIFIED AGENTS N.E.C. AT INDUSTRIAL PLANT
985	OTHER SPECIFIED AGENTS N.E.C. ON RANGE, DRILLFIELD
986	OTHER SPECIFIED AGENTS N.E.C. ON OBSTACLE COURSE
987	OTHER SPECIFIED AGENTS N.E.C. IN KITCHEN, MESS
988	OTHER SPECIFIED AGENTS N.E.C. IN HOME, QTRS
989	OTHER SPECIFIED AGENTS N.E.C. ON LAND, OTHER/UNSPECIFIED
990	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN IN AIR, SPACE(CRAFT)
991	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN ON SHIP, IN/ON WATER
992	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN AT AIRFIELD
993	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN AT DOCK
994	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN AT INDUSTRIAL PLANT
995	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN ON RANGE, DRILLFIELD
996	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN ON OBSTACLE COURSE
997	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN IN KITCHEN, MESS
998	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN IN HOME, QTRS
999	UNSPECIFIED CAUSATIVE AGENT; UNKNOWN ON LAND, OTHER/UNSPECIFIED

MED EVAL BOARD (MEB) STATUS AUG 31,1985 20:03 PAGE 1

MEB STATUS CODE	DESCRIPTION	FLAGS
C	CONFIRMED CANDIDATE	1
F	MEB FORWARDED TO HQ	
H	MEB HELD	
P	POTENTIAL CANDIDATE	
R	MEB RESOLVED	2

CAS STATUS CODE	DESCRIPTION	FLAGS
EXP	EXPIRED	2
III	INCAPACITATING ILLNESS OR INJ	1
REM	REMOVED AS CASUALTY	2
SC	SPECIAL CATEGORY	1
SI	SERIOUSLY ILL	1
TI	TERMINALLY ILL	1
VSI	VERY SERIOUSLY ILL	1

RELATIONSHIP	DESCRIPTION
AUNT	AUNT OF PATIENT
BROTHER	BROTHER OF PATIENT
DAUGHTER	DAUGHTER OF PATIENT
FATHER	FATHER OF PATIENT
FATHER INLAW	FATHER IN-LAW
FRIEND	FRIEND OF PATIENT
GRANDFATHER	GRANDFATHER OF PATIENT
GRANDMOTHER	GRANDMOTHER OF PATIENT
GUARDIAN	GUARDIAN OF PATIENT
HUSBAND	HUSBAND OF PATIENT
MOTHER	MOTHER OF PATIENT
MOTHER INLAW	MOTHER IN-LAW
OTHER	OTHER RELATIONSHIP
SELF	PATIENT
SISTER	SISTER OF PATIENT
SON	SON OF PATIENT
STEP FATHER	STEP FATHER OF PATIENT
STEP MOTHER	STEP MOTHER OF PATIENT
UNCLE	UNCLE OF PATIENT
WIFE	WIFE OF PATIENT

PROGNOSIS DESCRIPTION

CI	CONDITION IMPROVED
CU	CONDITION UNCHANGED
CW	CONDITION WORSE
EX	EXPECTED
FA	FAIR
GO	GOOD
GU	GUARDED
MO	MORIBUND
NE	NOT EXPECTED
PO	POOR
QU	QUESTIONABLE
RE	REMOVED FROM ROSTER

ARMY/AIR FORCE LENGTH OF SERVICE LIST AUG 21,1985 07:11 PAGE 1

LENGTH OF SERVICE	DESCRIPTION	CR CONVERSION	SERVICE FLAG
01D	ONE DAY	A1	A
01M	ONE MONTH	A3	A
02D	TWO DAYS	A1	A
02M	TWO MONTHS	A4	A
03D	THREE DAYS	A1	A
03M	THREE MONTHS	B1	A
04D	FOUR DAYS	A1	A
04M	FOUR MONTHS	B2	A
05D	FIVE DAYS	A1	A
05M	FIVE MONTHS	B3	A
06D	SIX DAYS	A1	A
06M	SIX MONTHS	C1	A
07D	SEVEN DAYS	A2	A
07M	SEVEN MONTHS	C2	A
08D	EIGHT DAYS	A2	A
08M	EIGHT MONTHS	C3	A
09D	NINE DAYS	A2	A
09M	NINE MONTHS	D1	A
0M	LESS THAN ONE MONTH		F
10D	TEN DAYS	A2	A
10M	TEN MONTHS	D2	A
11D	ELEVEN DAYS	A2	A
11M	ELEVEN MONTHS	D3	A
12D	TWELVE DAYS	A2	A
12M	TWELVE MONTHS	E1	A
13D	THIRTEEN DAYS	A2	A
13M	THIRTEEN MONTHS	E1	A
14D	FOURTEEN DAYS	A2	A
14M	FOURTEEN MONTHS	E1	A
15D	FIFTEEN DAYS	A2	A
15M	FIFTEEN MONTHS	F1	A
16D	SIXTEEN DAYS	A2	A
16M	SIXTEEN MONTHS	F1	A
17D	SEVENTEEN DAYS	A2	A
17M	SEVENTEEN MONTHS	F1	A
18D	EIGHTEEN DAYS	A2	A
18M	EIGHTEEN MONTHS	G1	A
19D	NINETEEN DAYS	A2	A
19M	NINETEEN MONTHS	G1	A
1M	1 MONTH		F
20D	TWENTY DAYS	A2	A
20M	TWENTY MONTHS	G1	A
21D	TWENTY ONE DAYS	A2	A
21M	TWENTY ONE MONTHS	H1	A
22D	TWENTY TWO DAYS	A2	A
22M	TWENTY TWO MONTHS	H1	A
23D	TWENTY THREE DAYS	A2	A
23M	TWENTY THREE MONTHS	H1	A
24D	TWENTY FOUR DAYS	A2	A
25D	TWENTY FIVE DAYS	A2	A
26D	TWENTY SIX DAYS	A2	A
27D	TWENTY SEVEN DAYS	A2	A
28D	TWENTY EIGHT DAYS	A2	A
29D	TWENTY NINE DAYS	A2	A
2M	2 MONTHS		F
30D	THIRTY DAYS	A2	A

LENGTH OF SERVICE	DESCRIPTION	CR CONVERSION	SERVICE FLAG
31D	THIRTY ONE DAYS	A2	A
3M	3 MONTHS		F
4M	4 MONTHS		F
5M	5 MONTHS		F
6M	6 MONTHS		F
7M	7 MONTHS		F
8M	8 MONTHS		F
9M	9-11 MONTHS		F
RR	UNKNOWN, NOT STATED		F

ARMY FACILITY TYPE

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FACILITY CODE	DESCRIPTION
OTH	OTHER, NON-FEDERAL, CIV HOSP
PUB	PUBLIC HEALTH SERVICE HOSP
VET	VETERANS HOSP

CODE	DESCRIPTION OF TRAUMA CODE
0	DIRECT RESULT OF ACTION BY OR AGAINST ORGANIZED ENEMY
1	OTHER BATTLE CASUALTIES, SO CLASSIFIED BY DEP REGS
2	RESULT OF INTERVENTION OF LEGAL AUTHORITY
3	ASSAULT OR INTENTIONALLY INFLICTED BY ANOTHER PERSON
4	SELF INFLICTED (INTENTIONAL)
5	OCCURING WHILE OFF DUTY (INCLUDES LEAVE, PASS AND AWOL)
6	SCHEMES (MANEUVERS) AND EXERCISES
7	ALL OTHER SCHEDULED TRAINING (INCLUDES BASIC,ETC)
8	OCCURING WHILE ON DUTY
9	UNKNOWN WHETHER ON OR OFF DUTY
C	INJURY, NOT CLASSIFIED AS BATTLE CASUALTY

RATE TABLE

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RATE CODE	DESCRIPTION	RATE
A1	INTER-AGENCY RATE	423.00
A2	IMET RATE	185.00
A3	CIV EMERGENCY RATE	452.00
B	DEPENDENT	6.80
C	OLD SERVICE HOME RATE	3.00
D7		111.11
DDA1	DD7 AT A-1 RATE	423.00
DDA2	DD7 AT A-2 RATE	185.00
DDA3	DD7 AT A-3 RATE	452.00
NC	NO CHARGE	0.00
SB	SUBSISTENCE	3.80
SF		3.85
SFA1	A-1 RATE CHARGE ON SF 1080	423.00
SFA2	A-2 RATE CHARGE ON SF 1080	185.00
SFA3	A-3 RATE CHARGE ON SF 1080	452.00
SFSB	SUBSISTENCE CHARGE ON SF 1080	5.06
W	A3 LESS SUBSISTENCE	3.80
X	A1 LESS SUBSISTENCE	3.80
Y	A1 LESS B RATE	6.55
Z	A2 LESS SUBSISTENCE	3.80

CR - SIGNATURE BLOCK

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INITIALS	FULL NAME
CED	CRAIG DAVIS
CFM	CHRIS MCNERNEY
XXX	SUPERVISOR NANE

CAUSE OF DEATH/SEPARATION LIST

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CODE	DESCRIPTION	SERVICE FLAG	ASSOC DIAGNOSIS NO
1	1ST DIAGNOSIS	AFN	1
2	2ND DIAGNOSIS	AFN	2
3	3RD DIAGNOSIS	AFN	3
4	4TH DIAGNOSIS	AFN	4
5	5TH DIAGNOSIS	AFN	5
6	6TH DIAGNOSIS	AFN	6
7	7TH DIAGNOSIS	AFN	7
8	8TH DIAGNOSIS	AFN	8
J	1ST DIAGNOSIS(INJURY SEPARATION)	A	1
K	2ND DIAGNOSIS(INJURY SEPARATION)	A	2
L	3RD DIAGNOSIS(INJURY SEPARATION)	A	3
M	4TH DIAGNOSIS(INJURY SEPARATION)	A	4
N	5TH DIAGNOSIS(INJURY SEPARATION)	A	5
O	6TH DIAGNOSIS(INJURY SEPARATION)	A	6
P	7TH DIAGNOSIS(INJURY SEPARATION)	A	7
R	8TH DIAGNOSIS(INJURY SEPARATION)	A	8

ICD 6TH DIGIT LIST

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CODE	DESCRIPTION	SERVICE FLAG
A	ASTERISK	AFN
D	DAGGER	AFN
J	MULT FRACTURE	F
S	SECONDARY	AN
T	MULTIPLE CODE	A

AIRFORCE ICD 7TH DIGIT

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CODE	DESCRIPTION
0	NO INFECTION OR COMPLICATION
1	POST OP INFECTION, THIS HOSP
2	POST OP INFECTION, OTHER HOSP
3	OTHER HOSP INFECTION, THIS HOSP
4	OTHER HOSP INFECTION, OTHER HOSP
5	POST OP COMPLICATION, THIS HOSP
6	POST OP COMPLICATION, OTHER HOSP
7	OTHER COMPL, THIS HOSP
8	OTHER COMPL, OTHER HOSP

0	TREATED AT REPORTING MTF
9	TREATED/CURED PRIOR TO THIS HOSP
Z	CRD AND CASES ENTIRELY ABS SICK

CODE	DESCRIPTION
N	NOT PRE-EXISTING
Y	PRE-EXISTING CONDITION

CODE	TABLES DESCRIPTION
1A	UNDETERMINED, LIVEBIRTH
1B	LEFT/RIGHT OCCIPITOANTERIOR, LIVEBITH
1C	LEFT/RIGHT OCCIPITOTRANSVERSE, LIVEBIRTH
1D	LEFT/RIGHT OCCIPITOPOSTERIOR, LIVEBIRTH
1E	DOUBLE FOOTLING, LIVEBIRTH
1F	FOOTLING, LIVEBIRTH
1H	LEFT/RIGHT SACROANTERIOR, LIVEBIRTH
1J	LEFT/RIGHT SACROPOSTERIOR, LIVEBIRTH
1K	FRANK (OR SINGLE), LIVEBIRTH
1L	COMPLETE (OR DOUBLE), LIVEBIRTH
1M	INCOMPLETE, LIVEBIRTH
1N	LEFT/RIGHT FRONTOANTERIOR, LIVEBIRTH
1P	LEFT/RIGHT FRONTOPOSTERIOR, LIVEBIRTH
1Q	LEFT/RIGHT MENTOANTERIOR, LIVEBIRTH
1R	LEFT/RIGHT MENTOPOSTERIOR, LIVEBIRTH
1S	LEFT/RIGHT SCAPULOANTERIOR, LIVEBIRTH
1T	LEFT/RIGHT SCAPULOPOSTERIOR, LIVEBIRTH
1W	COMPOUND (POSITION UNSPECIFIED), LIVEBIRTH
2A	UNDETERMINED, STILLBIRTH
2B	LEFT/RIGHT OCCIPITOANTERIOR, STILLBIRTH
2C	LEFT/RIGHT OCCIPITOTRANSVERSE, STILLBIRTH
2D	LEFT/RIGHT OCCIPITOPOSTERIOR, STILLBIRTH
2E	DOUBLE FOOTLING, STILLBIRTH
2F	FOOTLING, STILLBIRTH
2H	LEFT/RIGHT SACROANTERIOR, STILLBIRTH
2J	LEFT/RIGHT SACROPOSTERIOR, STILLBIRTH
2K	FRANK, (OR SINGLE), STILLBIRTH
2L	COMPLETE, (OR DOUBLE), STILLBIRTH
2M	INCOMPLETE, STILLBIRTH
2N	LEFT/RIGHT FRONTOANTERIOR, STILLBIRTH
2P	LEFT/RIGHT FRONTOPOSTERIOR, STILLBIRTH
2Q	LEFT/RIGHT MENTOANTERIOR, STILLBIRTH
2R	LEFT/RIGHT MENTOPOSTERIOR, STILLBIRTH
2S	LEFT/RIGHT SCAPULOANTERIOR, STILLBIRTH
2T	LEFT/RIGHT SCAPULOPOSTERIOR, STILLBIRTH
2W	COMPOUND (POSITION UNSPECIFIED), STILLBIRTH

WHERE PROCEDURE PERFORMED LIST

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OPERATION CODE	DESCRIPTION	SERVICE CODE	FLAGS
B	PRINCIPLE OPERATION IN THIS HOSPITAL	FN	0
D	THIS MTF	A	
N	ASSOCIATED OPERATION IN THIS HOSPITAL	FN	0
T	NON-HOSPITAL MTF	A	1
U	OPERATION PERFORMED IN ANOTHER HOSPITAL	AFN	1
X	IN SAME DAY SURGERY PGM	A	

ARMY AGE TABLE

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CODE	DESCRIPTION
T1	PRE-TERM
T2	NORMAL TERM
T3	POST-TERM

CODE	DESCRIPTION
A1	PRE-TERM - LARGE FOR GEST AGE - SINGLE BIRTH
A2	PRE-TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
A3	PRE-TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
A4	PRE-TERM - LARGE FOR GEST AGE,ONE OF MULTIPLE,MATES ALL LIVEBORN
A5	PRE-TERM - LARGE FOR GEST AGE,ONE OF MULTIPLE,MATES NOT ALL LIVEBORN
B1	PRE-TERM - SMALL FOR GEST AGE - SINGLE BIRTH
B2	PRE-TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
B3	PRE-TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
B4	PRE-TERM - SMALL FOR GEST AGE,ONE OF MULTIPLE,MATES ALL LIVEBORN
B5	PRE-TERM - SMALL FOR GEST AGE,ONE OF MULTIPLE,MATES ALL NOT LIVEBORN
K1	POST-TERM - LARGE FOR GEST AGE, SINGLE BIRTH
K2	POST-TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
K3	POST-TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
K4	POST-TERM - LARGE FOR GEST AGE, ONE OF MULTIPLE, MATES LIVEBORN
K5	POST-TERM - LARGE FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
M1	POST-TERM - AVERAGE FOR GEST AGE, SINGLE BIRTH
M2	POST-TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
M3	POST-TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
M4	POST-TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
M5	POST-TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
P1	PRE-TERM - AVERAGE FOR GEST AGE, SINGLE BIRTH
P2	PRE-TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
P3	PRE-TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
P4	PRE-TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
P5	PRE-TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
R1	POST-TERM - SMALL FOR GEST AGE, SINGLE BIRTH
R2	POST-TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
R3	POST-TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
R4	POST-TERM - SMALL FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
R5	POST-TERM - SMALL FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
T1	TERM - LARGE FOR GEST AGE, SINGLE BIRTH
T2	TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
T3	TERM - LARGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
T4	TERM - LARGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
T5	TERM - LARGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL NOT LIVEBORN
X1	TERM - AVERAGE FOR GEST AGE, SINGLE BIRTH
X2	TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
X3	TERM - AVERAGE FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
X4	TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
X5	TERM - AVERAGE FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN
Y1	TERM - SMALL FOR GEST AGE, SINGLE BIRTH
Y2	TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE LIVEBORN
Y3	TERM - SMALL FOR GEST AGE, ONE OF TWINS, MATE STILLBORN
Y4	TERM - SMALL FOR GEST AGE, ONE OF MULTIPLE, MATES ALL LIVEBORN
Y5	TERM - SMALL FOR GEST AGE, ONE OF MULTIPLE, SOME MATES STILLBORN

RADT REPORTS MENU FILE AUG 31,1985 20:07 PAGE 1

REPORT NUMBER	REPORT DESCRIPTION	REPORT TYPE	SERVICE FLAGS	PRIMARY PRINTER ID	DELETE DATE
1	A & D REPORT	NIGHTLY	AFN	A&D1	
10	STATUS OUT ROSTER	SPECIAL CASE	AFN	A&D1	
12	UCA BED DAYS RECAP	MONTHLY	AFN	A&D1	
2	ALPHA ROSTER	NIGHTLY	AFN	A&D1	
20	A&D RECAP	NIGHTLY	A	A&D1	
21	PATIENT STRENGTH REPORT	NIGHTLY	FN	A&D1	
22	UCA DISPOSITION REPORT	MONTHLY	AFN	A&D1	
3	WARD NURSING REPORT	NIGHTLY	AFN	A&D1	
500	INJURY REPORT	SPECIAL CASE	AFN	A&D1	
502	DEATH REPORT	SPECIAL CASE	AFN	A&D1	
504	COMMAND INTEREST REPORT	SPECIAL CASE	AFN	A&D1	
505	ADMISSION NOTIFICATION LETTERS	NIGHTLY	A	A&D1	
506	PREADMISSION LIST	SPECIAL CASE	AFN	A&D1	
509	PROJECTED DISPOSITIONS BY AFSC/MOS	SPECIAL CASE	AFN	A&D1	
510	DISPOSITION NOTIFICATION LETTERS	NIGHTLY	AF	A&D1	
511	PATIENT CHARGE ROSTER	NIGHTLY	A	A&D1	
520	DISPOSITION SUMMARY BY NAME	MONTHLY	N	A&D1	
521	DISPOSITION SUMMARY BY REG NO	MONTHLY	N	A&D1	
522	ADMISSION SUMMARY BY NAME	MONTHLY	N	A&D1	
523	ADMISSION SUMMARY BY REG NO	MONTHLY	N	A&D1	
530	ADMISSION NOTIFICATION LETTERS	NIGHTLY	N	A&D1	
6	VSI/SI/SC REPORT	NIGHTLY	AFN	A&D1	
8	LONG TERM PATIENT ROSTER	SPECIAL CASE	AFN	A&D1	
9	DAILY ADMISSIONS BY DIAGNOSIS	NIGHTLY	AFN	A&D1	

QA REPORTS MENU FILE SEP 4,1985 14:38 PAGE 1

REPORT NUMBER	REPORT DESCRIPTION	REPORT TYPE	SERVICE FLAGS	PRIMARY PRINTER ID	DELETE DATE
50	PROBLEM AUDIT	SPECIAL CASE	AFN	QA1	
51	OCCURRENCE SCREENING AUDIT - EMERGENCY SERVICES BY PROVIDER	SPECIAL CASE	AFN	QA1	
52	OCCURRENCE SCREENING AUDIT - INPATIENT BY PROVIDER	SPECIAL CASE	AFN	QA1	
53	OCCURRENCE SCREENING SUSPENSE LIST - EMERGENCY SERVICES	SPECIAL CASE	AFN	QA1	
54	OCCURRENCE SCREENING SUSPENSE LIST - INPATIENT	SPECIAL CASE	AFN	QA1	
55	OCCURRENCE SCREENING PULL LIST - INPATIENT	MONTHLY	F	QA1	
56	OCCURRENCE SCREENING PULL LIST - INPATIENT	MONTHLY	AN	QA1	
57	OCCURRENCE SCREENING PULL LIST - EMERGENCY SERVICES	MONTHLY	AFN	QA1	
58	OCCURRENCE SCREENING SUMMARY - EMERGENCY SVC BY PROVIDER	SPECIAL CASE	AFN	QA1	
59	OCCURRENCE SCREENING SUMMARY - EMERGENCY SVC FACILITY	SPECIAL CASE	AFN	QA1	
60	OCCURRENCE SCREENING SUMMARY - INPATIENT BY PROVIDER	SPECIAL CASE	AFN	QA1	
61	OCCURRENCE SCREENING SUMMARY - INPATIENT SPECIALTY	SPECIAL CASE	AFN	QA1	
62	OCCURRENCE SCREENING SUMMARY - INPATIENT FACILITY	SPECIAL CASE	AFN	QA1	
63	DELINQUENT OCCURRENCE SCREENING LIST	MONTHLY	AFN	QA1	
65	BLOOD UTILIZATION PULL LIST	MONTHLY	AFN	QA1	
67	INCIDENT SUMMARY BY INCIDENT DATE/TIME	MONTHLY	AFN	QA1	
72	SURGICAL OPERATIONS REPORT	SPECIAL CASE	AFN	QA1	
73	DISPOSITION BY DIAGNOSIS	SPECIAL CASE	AFN	QA1	
74	DIAGNOSIS INDEX BY PROVIDER	SPECIAL CASE	AFN	QA1	
75	SURGICAL INDEX BY PROVIDER	SPECIAL CASE	AFN	QA1	

CR REPORTS MENU FILE

AUG 31,1985 20:08 PAGE 1

REPORT NUMBER	REPORT DESCRIPTION	REPORT TYPE	SERVICE FLAGS	PRIMARY PRINTER ID	DELETE DATE
14	ROSTER OF DELINQUENT RECORDS	NIGHTLY	AFN	CR1	
15	INCOMPLETE INPNT MED RECS BY PROVIDER	SPECIAL CASE	AFN	CR1	
501	CLINICAL RECORDS RETURNED TO A & D	SPECIAL CASE	AFN	CR1	
77	CR END OF MONTH SUMMARY	MONTHLY	N	CR1	

SYS MGMT REPORTS FILE AUG 31,1985 20:08 PAGE 1

REPORT NUMBER	REPORT DESCRIPTION	REPORT TYPE	SERVICE FLAGS	PRIMARY PRINTER ID	DELETE DATE
11	LIST CURRENT PASSWORDS	SPECIAL CASE	AFN	CONSOLE	
7	INVALID SIGN ON LOG	SPECIAL CASE	AFN	A&D1	

PROFILING REPORTS MENU FILE AUG 31,1985 19:03 PAGE 1

REPORT NUMBER	REPORT DESCRIPTION	REPORT TYPE	SERVICE FLAGS	PRIMARY PRINTER ID	DELETE DATE
64	CREDENTIAL PULL LIST	SPECIAL CASE	AFN	QA1	
68	PROVIDER PROFILE	SPECIAL CASE	AFN	QA1	
70	PROVIDER/PROCEDURE MORTALITY SUMMARY	SPECIAL CASE	AFN	QA1	
71	PROVIDER PROCEDURE SUMMARY	SPECIAL CASE	AFN	QA1	
80	PROVIDERS WITH INSUFFICIENT CONTINUING EDUCATION	SPECIAL CASE	AFN	QA1	

INCIDENT PERSON TYPE SEP 5,1985 16:26 PAGE 1

TYPE	DESCRIPTION
A	INPATIENT
B	OUTPATIENT
C	VISITOR
D	STAFF
OTHER	SPECIFY IN SINGLE QUOTES (E.G. 'VIP VISITOR')

INCIDENT TYPE

SEP 4,1985 14:39 PAGE 1

TYPE OF INCIDENT	DESCRIPTION
A	MEDICATION
B	TREATMENT
C	EQUIPMENT FAILURE
D	PROCEDURE/TEST
E	SUICIDE
F	FALL
G	FIRE
H	ALTERCATION
I	THEFT
J	COMPLAINT
K	ALCOHOL RELATED
OTHER	SPECIFY IN SINGLE QUOTES (E.G. 'FIST FIGHT')

INCIDENT LOC	DESCRIPTION
A	PATIENT ROOM
B	STAIRWAY
C	ER
D	BATH/WASH ROOM
E	NURSE STATION
F	TREATMENT ROOM
G	HALLWAY
H	OR
I	ICU/CCU
J	FACILITY GROUNDS
OTHER	SPECIFY IN SINGLE QUOTES (E.G. 'WAITING ROOM')

PERSONNEL TYPE	DESCRIPTION
A	PHYSICIAN
B	NURSE
C	MED STUDENT
D	RAD STAFF
E	LAB STAFF
F	RESIDENT
G	INTERN
H	PHARM STAFF
I	DIET STAFF
J	NURSE PRACTITIONER
K	PA
L	CORPSMAN
M	MAINT STAFF
N	HOUSEKEEPING STAFF
OTHER	SPECIFY IN SINGLE QUOTES (E.G. 'WARD CLERK')

ACTION CODE BYTE 1

SEP 4,1985 14:39 PAGE 1

FIRST DIGIT	DESCRIPTION
A	CREDENTIALS COMMITTEE
B	BLOOD UTILIZATION COMMITTEE
C	PHAR & THERAPEUTIC COMMITTEE
D	SURGICAL CASE REVIEW COMMITTEE
E	INFECTION CONTROL COMMITTEE
F	RISK MANAGER
G	COMMANDER
H	CHIEF OF SERVICE
I	GRADUATE MEDICAL EDUC
J	EXECUTIVE COMMITTEE
K	QA COMMITTEE
L	QA COORDINATOR
M	PEER REVIEW COMMITTEE

ACTION CODE BYTE 3

ACTION CODE CHARACTER	DESCRIPTION
A	FAILED CRITERIA BUT WITHIN PRACTICE PARAMETERS
B	CLINICAL PRIVILEGES LIMITED
C	CLINICAL PRIVILEGES SUSPENDED
D	CLINICAL PRIVILEGES REVOKED
E	REMEDIAL TRAINING STIPULATED
F	PROCTOR ASSIGNED
G	CLINICAL PRIVILEGES LIMITED AND REMEDIAL TRAINING STIPULATED
H	CLINICAL PRIVILEGES LIMITED AND PROCTOR ASSIGNED
I	PRIVILEGES LIMITED, TRAINING STIPULATED AND PROCTOR ASSIGNED
J	CLINICAL PREVILEGES SUSPENDED AND TRAINING STIPULATED
K	CLINICAL PRIVILEGES SUSPENDED AND PROCTOR ASSIGNED
L	PRIVILEGES SUSPENDED, TRAINING STIPULATED & PROCTOR ASSIGNED
M	CLINICAL PRIVILEGES REVOKED AND REMEDIAL TRAINING STIPULATED
N	CLINICAL PRIVILEGES REVOKED AND PROCTOR ASSIGNED
P	PRIVILEGES REVOKED, TRAINING STIPULATED AND PROCTOR ASSIGNED

DOD REPORTED SURGICAL PROCEDURES SEP 4,1985 14:40 PAGE 1

PROCEDURE NBR	PROCEDURE DESC	NORMAL PERCENTAGE	PROCEDURE CODE
1	CAESARIAN SECTION, ALL	*	5740
			5741
			5742
			5748
			5749
2	DILATATION AND CURETTAGE	*	5690
3	REPAIR, INGUINAL/FEMORAL HERNIA	*	5530
			5531
			5532
			5533
4	TUBAL LIGATION	*	5664
5	LAPAROTOMY	20	5541
6	APPENDICTOMY	*	5470
			5471
			5479
7	TONSILLECTOMY AND/OR ADENOIDECTOMY	*	5281
			5282
			5283
			5284
			5285
			5286
			5287
			5288
			5289
8	OPEN REDUCTION OF FRACTURE	*	5791
			5792
9	CHOLECYSTECTOMY	3	5511
10	ABDOMINAL HYSTERECTOMY	*	5682
			5683
11	VAGINAL HYSTERECTOMY	*	5682
12	THORACOTOMY	25	5340
13	TRANSURECTH RESECTION, PROSTATE	*	5601
14	SALPINGO-OOPHORECTOMY	*	5653
			5655
15	EXCISION INTERVERTEBRAL DISC	*	5803
16	EXCISION SIMILUNAR CARTILAGE, KNEE	*	5804
17	EXTRACTION, INTRAOCULAR LENS	*	5142
			5143
			5144
			5145
			5146
18	THYROIDECOTOMY, ALL	*	5061
			5062
			5063
			5064
19	MASTECTOMY, ALL	*	5861
			5862
			5863
			5864
			5865
20	COLECTOMY, PARTIAL	15	5455
21	ARTHROPLASTY, KNEE	*	5814
22	REPAIR, HERNIA, ABDOMINAL WALL	*	5535
23	TRANSURETHRAL RESECTION, BLADDER	*	5573
24	ENDARTERECTOMY	3	5381
25	BYPASS ANASTAMOSIS, HEART	10	5361
26	CRANIOTOMY	20	5011

WARD PROFILE

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WARD ID	DESCRIPTION	TOTAL BEDS	TOTAL PREADMITS	OTHER BEDS BLOCKED	TOTAL BEDS OCCUPIED	DELETE DATE
2W	GENERAL SURGERY	15				
3N	PEDIATRICS	12	0		0	
4E	INTERNAL MEDICINE	20	0		2	
4N	PSYCHIATRIC	5				
6N	OB/GYN	10				
6S	LABOR/DELIVERY	15	0		1	
6W	NURSERY	20	0		1	
ICU	INTENSIVE CARE UNIT	15				

Appendix G

FILE DESCRIPTIONS

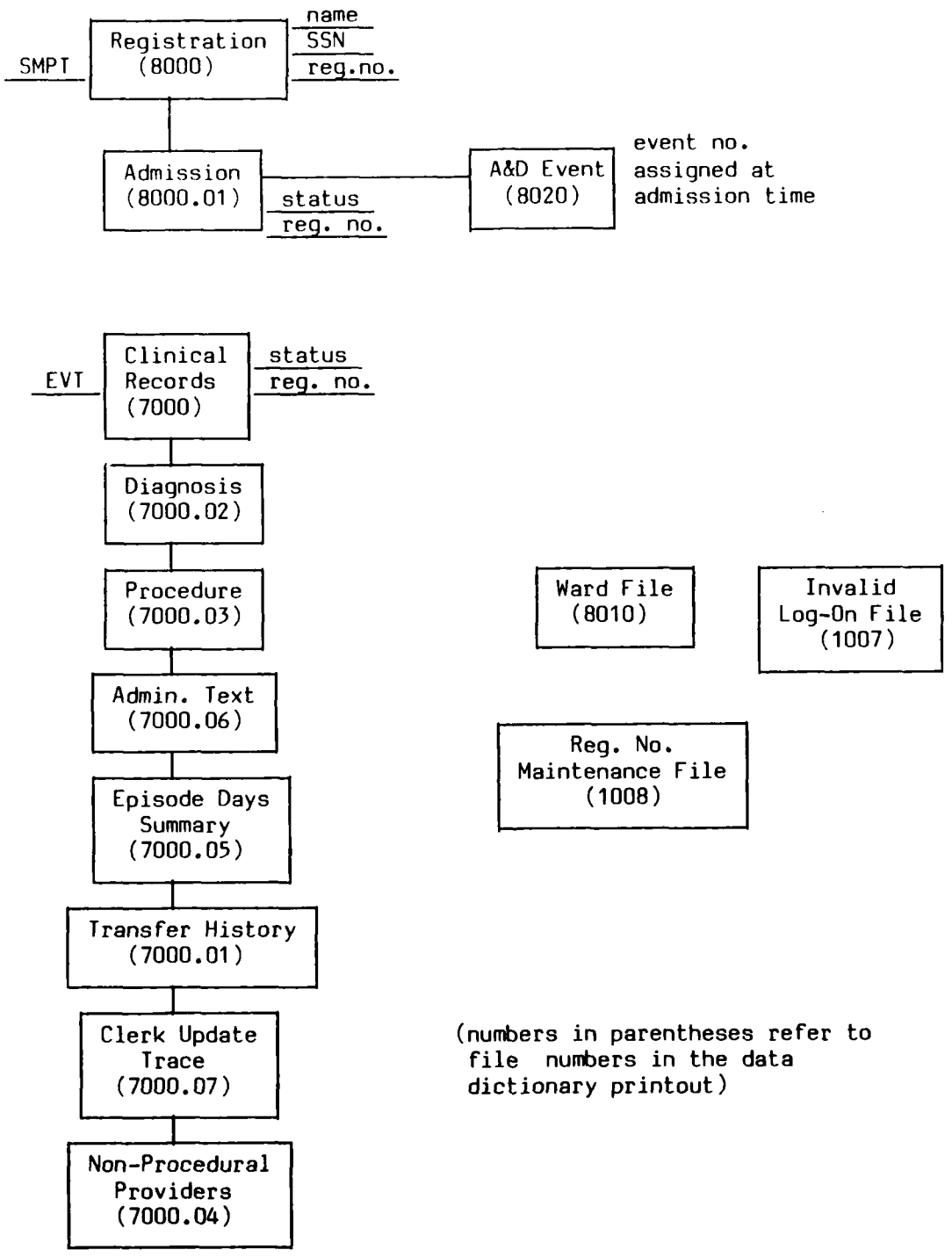
TABLE OF CONTENTS

BY FILE NUMBER

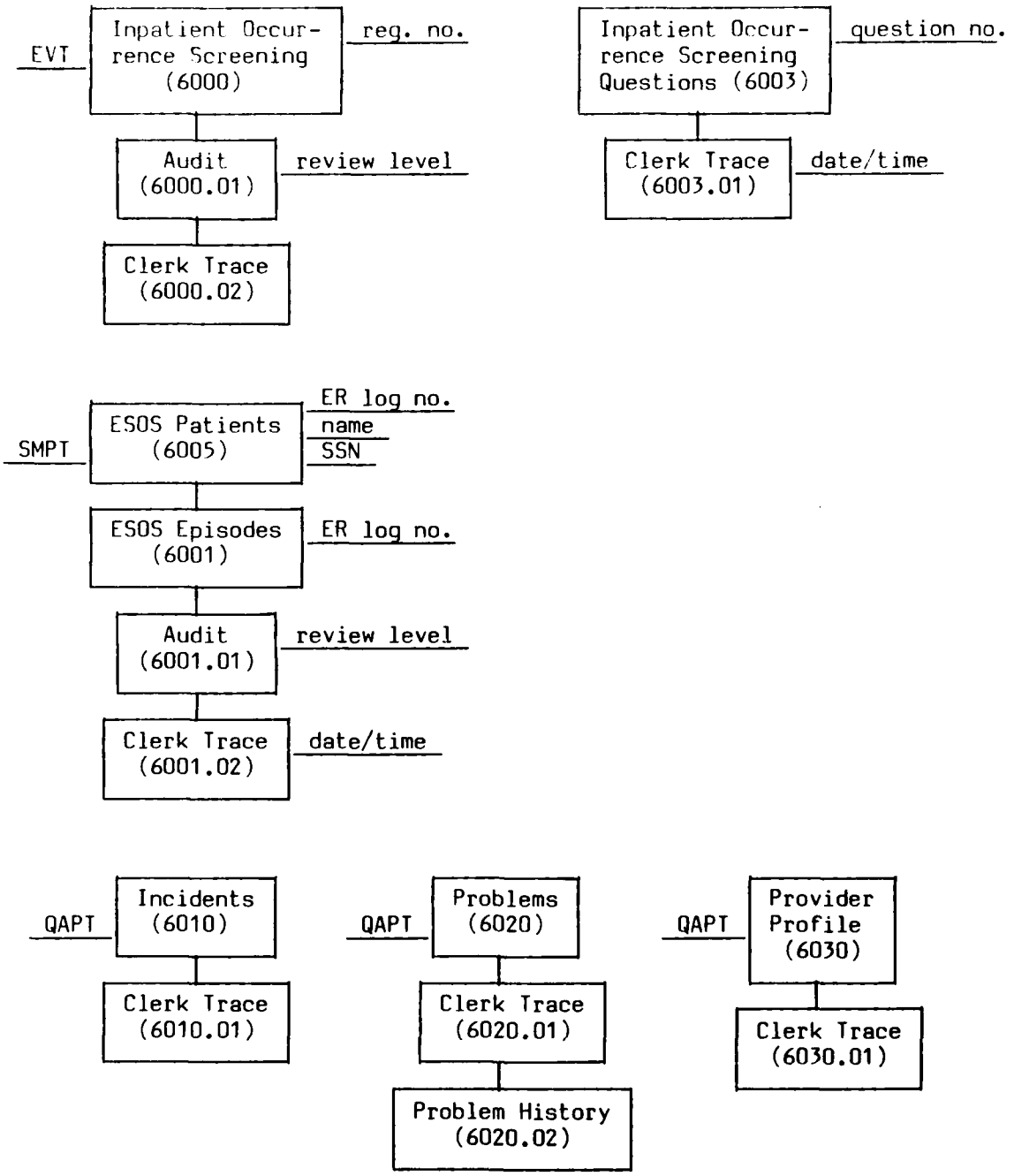
FILE		PAGE
1004	Doctor File	
1011	MTF Profile	
6000	Inpatient Occurrence Screening Checklist	
6000.01	IP OS Audit Subfile	
6000.02	IP OS Clerk Edit Subfile	
6001	Emergency Room Occurrence Screening Checklist	
6001.01	ER OS Audit Subfile	
6001.02	ER OS Clerk Trace Subfile	
6005	Emergency Top Level File	
6005.01	ER Log No. Subfile	
6010	Incident File	
6010.01	Incident Clerk Trace Subfile	
6020	Problem File (QA)	
6020.01	Problem Clerk Trace Subfile	
6020.02	Problem History Subfile	
6030	Provider Profile	
6030.01	Provider Profile Clerk Trace Subfile	
7000	Clinical Record File	
7000.01	Transfer History Subfile	
7000.02	Diagnosis Subfile	
7000.03	Procedure Subfile	
7000.04	Non-Procedural Providers Subfile	
7000.05	Episode Days Subfile	
7000.06	Administrative Text Subfile	
7000.07	Clerk Update Trace File (CR)	
8000	Registration File	
8000.01	Admission File	
8010	Ward File	
8020.99	A&D Event Subfile	

TABLE OF CONTENTS BY FILE NAME (Cont'd.)

FILE		PAGE
8020.99	A&D Event Subfile	
7000.06	Administrative Text Subfile	
8000.01	Admission	
7000.07	Clerk Update Trace Subfile (CR)	
7000	Clinical Record File	
7000.02	Diagnosis Subfile	
1004	Doctor File	
6001	Emergency Room Occurrence Screening Checklist	
6005	Emergency Top Level File	
7000.05	Episode Da' ; Subfile	
6001.01	ER OS Audit Subfile	
6001.02	ER OS Clerk Trace Subfile	
6005.01	ER Log No. Subfile	
6010.01	Incident Clerk Trace Subfile	
6010	Incident File	
6000	Inpatient Occurrence Screening Checklist	
6000.01	IP OS Audit Subfile	
6000.02	IP OS Clerk Edit Subfile	
1011	MTF Profile	
7000.04	Non-Procedural Providers Subfile	
6020	Problem File (QA)	
6020.01	Problem Clerk Trace Subfile	
6020.02	Problem History Subfile	
7000.03	Procedure Subfile	
6030	Provider Profile	
6030.01	Provider Profile Clerk Trace Subfile	
8000	Registration	
7000.01	Transfer History Subfile	
8010	Ward File	



DATA BASE FORMAT (page 1 of 2)



DATA BASE FORMAT (page 2 of 2)

UH007

FILE 1011 - MTF PROFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
AUTO ER LOG NO FLAG	12	SET Y-YES N-NO	1	
AUTO REG FLAG	3		1	
CR ARCHIVE MONTHS	23	NUMERIC		
DAYS TO DELINQUENCY OS LIST	9	NUMERIC	2	
DELINQ DAYS CR	22	NUMERIC	2	
DELINQ DAYS MEDREC COMP	10	NUMERIC	2	
INDEX CARDS PER SET	4	NUMERIC	1	
INVALID ATTEMPT COUNT	8	NUMERIC	1	
MTF CITY	18		20	
MTF CODE	1	FREE TEXT	5	
MTF NAME	.01		20	
MTF SERVICE	6	SET A-ARMY/ F-AIR FORCE/ N-NAVY	1	
MTF STATE	19	TABLE 1015		
MTF ZIP CODE	20		10	
PAD BLDG/ROOM	17		20	
PAD OFFICE SYMBOL	13		10	
SIGNATURE BLOCK LINE 1	14		27	
SIGNATURE BLOCK LINE 2	15		27	
SIGNATURE BLOCK LINE 3	16		27	
TRAINING DATE	21	DATE		
TRAINING FLAG	7		1	
VERSION NUMBER	2	NUMERIC	5	
WAR	5	SET Y-YES N-NO	1	

FILE 8000 - REGISTRATION FILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
AERONAUTICAL RATING	13	TABLE 1009	3	A,F
CIVILIAN OCCUPATION	16		25	
COMMAND INTEREST 1	31	TABLE 1016	3	
COMMAND INTEREST 2	32	TABLE 1016	3	
COMMAND INTEREST 3	33	TABLE 1016	3	
CURRENT REGISTER NUMBER	17		8	
DATE LAST ADM	34	DATE	11	
DATE LAST DISP	35	DATE	11	
DOB (DATE OF BIRTH)	5	DATE	11	
DUTY ADDRESS	45		28	
DUTY CITY	46		20	
DUTY STATE	47	TABLE 1015	2	
DUTY ZIP CODE	48		9	
EDIT FLAG	2	(internal use only)	1	
FLYING STATUS	12	TABLE 1014	2	
FMP (FAMILY MEMBER PREFIX)	3	TABLE 1012	11	
HOME PHONE	25		19	
HOME STATE	24	TABLE 1015	3	A
ID CARD DATE	27	DATE (INDEF)	1	
ID CARD NUMBER	28		10	N
MAJOR COMMAND	44	TABLE 1017	3	F
MARITAL STATUS	8	SET D-DIVORCED A-ANNULLED S-SINGLE I-INTERLOCUTORY L-LEGALLY SEPARATED W-WIDOWED Z-UNKNOWN	1	
MILITARY SPECIALTY	15	TABLE 1029	5	
PATIENT CATEGORY	6	TABLE 1002	3	
PATIENT CITY	21		20	
PATIENT NAME	.01		27	
PATIENT STATE	22	TABLE 1015	2	
PATIENT STREET ADDRESS	20		28	
PAY GRADE	42	Calculated from Table 1006	2	
PREVIOUS REGISTER NUMBER	18		8	
PRIMARY CARE PROVIDER	29	TABLE 1004	6	
PRIMARY MTF	30	TABLE 1005	4	
RACE	9	TABLE 1024	1	
RECORD LAST UPDATED	19	DATE	11	
RELIGION	10	TABLE 1000	3	
REMARKS	37		50	
RGCARD	51	(internal use only)		
RGFORM	50	(internal use only)		
SERVICE	43	TABLE 1023	2	

FILE 8000 - REGISTRATION FILE (Cont'd.)

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
SEX	7	SET M-MALE F-FEMALE Z-UNKNOWN	1	
SPONSOR RANK	41	TABLE 1006	3	
SSN (SOCIAL SECURITY NUMBER)	4		11	
UNIT ID	49		7	
VERIFY DATE	39		11	
VERIFY FLAG	38		3	
WORK PHONE	26		19	
ZIP CODE	23		9	

FILE 8000.01 - ADMISSION FILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ABSENT STATUS	50	TABLE 2002	2	
ABSENT STATUS DATE/TIME	51	DATE/TIME	16	
ADM CLERK	35		3	
ADM DATE/TIME	2	DATE/TIME	16	
ADM DIAG CODE	4	TABLE DX	5	
ADM DIAG TEXT	16		50	
ADM PHYSICIAN	27	TABLE 1004	6	
ADM REMARKS	34	FREE TEXT	66	
ARCHIVE DATE	91	DATE	11	
ATTENDING PHYS DATE ASSIGN	19	DATE	11	
ATTENDING PHYSICIAN	7	TABLE 1004	6	
BED	83	FREE TEXT	2	
CANCEL CLERK	77	FREE TEXT	3	
CANCEL DATE	79	DATE	11	
CANCEL PHYS AUTH	78	TABLE 1004	6	
CANCEL REASON	80	FREE TEXT	50	
CASUALTY DATE COMMAND NOTIFIED	107	DATE	11	
CASUALTY DATE NOK NOTIFIED	72	DATE	11	
CASUALTY DIAGNOSIS	71	FREE TEXT	25	
CASUALTY ROSTER DATE	73	DATE	11	
CASUALTY ROSTER DATE REM	75	DATE	11	
CASUALTY STATUS	70	TABLE 2011	3	
CASUALTY STATUS DATE CHG	84	DATE	11	
CAUSE INJ CODE	88	TABLE 2009	3	
CAUSE INJ TEXT PT 1	89	FREE TEXT	41	
CAUSE INJ TEXT PT 2	90	FREE TEXT	79	
CIVILIAN PHYSICIAN PHONE	62	FREE TEXT	18	
CLIN SVC	8	TABLE 2005	4	
CLIN SVC DATE ASSIGNED	14	DATE/TIME	16	
COORD MED OFFICER	60	FREE TEXT	27	
COUNTRY OF ADM	85	TABLE 1015	2	A
DISP CLERK	76	FREE TEXT	3	
DISP DATE/TIME	3	DATE/TIME	16	
DISP MTF	11	TABLE 1005	6	
DISP PHYS AUTH	101	TABLE 1004	6	
DISP PHYS ORDERING	100	TABLE 1004	6	
DISP TYPE	10	TABLE 2007	4	
DR (DENTAL RECORD)	29	SET Y-YES N-NO	1	N
EMERGENCY ADDRESS	45	FREE TEXT	28	
EMERGENCY CITY	46	FREE TEXT	20	
EMERGENCY NAME	43	FREE TEXT	27	
EMERGENCY PHONE	49	FREE TEXT	14	
EMERGENCY RELATION	44	TABLE 2012	12	
EMERGENCY STATE	47	TABLE 1015	2	
EMERGENCY ZIP CODE	48	FREE TEXT	9	
EVT (EVENT NUMBER)	81	NUMERIC		

FILE 8000.01 - ADMISSION FILE (Cont'd.)

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
EXPIRED TERM SVCE	18	DATE	11	
FACILITY TYPE	53	TABLE 2015	3	A
HR (HEALTH RECORD)	28	SET Y-YES N-NO	1	N
INITIAL ADM DATE (TRF IN)	64	DATE	11	
INITIAL ADM MTF	63	TABLE 1005	6	
LENGTH SVC	17			
MEAL CARD	25	SET Y-YES N-NO	1	F
MEB CANDIDATE	65	TABLE 2010	1	
MEB DATE CONFIRMED	66	DATE	11	
MEB DATE IDENTIFIED	68	DATE	11	
MEB DATE RESOLVED	69	DATE	11	
MEB REMARKS	67		65	
MIL THEATER OPERATIONS	86	TABLE 2008	3	N
MSA BALANCE	13	NUMERIC		
NBR ADMISSION PRODUCTS	104	(for internal use)		
NBR REQ 3X5	102	(for internal use)		
NBR REQ EMBOSSED CARDS	103	(for internal use)		
NEXT OF KIN ADDRESS	38	FREE TEXT	28	
NEXT OF KIN CITY	39	FREE TEXT	20	
NEXT OF KIN NAME	36	FREE TEXT	27	
NEXT OF KIN PHONE	42	FREE TEXT	14	
NEXT OF KIN RELATION	37	TABLE 2012	12	
NEXT OF KIN STATE	40	TABLE 1015	2	
NEXT OF KIN ZIP CODE	41	FREE TEXT	9	
NONMILITARY MTF ADDRESS	55	FREE TEXT	28	
NONMILITARY MTF CITY	56	FREE TEXT	20	
NONMILITARY MTF NAME	54	FREE TEXT	27	
NONMILITARY MTF PHONE	59	FREE TEXT	18	
NONMILITARY MTF STATE	57	TABLE 1015	2	
NONMILITARY MTF ZIP CODE	58		9	
ON DUTY FLAG	87	SET Y-ON DUTY N-NOT ON DUTY	1	N
OR (ORDERS)	32	SET Y-YES N-NO	1	N
PE (PERSONAL EFFECTS)	33	SET Y-YES N-NO	1	N
PR (PHYSICAL RECORD)	31	SET Y-YES N-NO	1	N
PREVIOUS ADM	22	FREE TEXT	3	
PRIMARY DISP DIAGNOSIS	105	TABLE DX	5	
PRIMARY PROCEDURE	106	TABLE PRC	4	
PROGNOSIS	74	TABLE 2013	2	
PROJ DISP DATE	24	DATE	11	
PROJ DISP TYPE	23	TABLE 2007	4	

FILE 8000.01 - ADMISSION FILE (Cont'd.)

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
RECORD STATUS FLAG	12	SET A-ARCHIVED C-CANCELLED D-DISPOSITIONED I-INPATIENT P-IN CLINICAL RECORDS M-MEDICAL HOLD (NAVY ONLY)	1	
REG NO NEWBORN 1/MOTHER	92	NUMERIC	8	
REG NO NEWBORN 2	93	NUMERIC	8	
REG NO NEWBORN 3	94	NUMERIC	8	
REG NO NEWBORN 4	95	NUMERIC	8	
REG NO NEWBORN 5	96	NUMERIC	8	
REG NO NEWBORN 6	97	NUMERIC	8	
REG NO NEWBORN 7	98	NUMERIC	8	
REG NO NEWBORN 8	99	NUMERIC	8	
REG NUMBER	.01		8	
RETURN DATE/TIME	52	DATE/TIME	16	
ROOM	82	FREE TEXT	4	
SOURCE ADMISSION	5	TABLE 2001	3	
SR (SERVICE RECORD)	30	SET Y-YES N-NO	1	N
TRAUMA CODE	108	TABLE 2016	1	FN
TYPE CASE	6	TABLE 2004	3	
WARD	9	TABLE 8010	4	
WARD DATE/TIME	15	DATE/TIME	16	

FILE 7000 - CLINICAL RECORD FILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ACTION (HOLD AREA)	24	(for internal use)	1	
ADMIT DATE	9	DATE	11	
ADMIT DATE TAPE	9.5	DATE	11	
AERONAUTICAL RATING	104	TABLE 1009	1	
AGE	63	FREE TEXT		
ANESTHETIC RISK CODE	67	NUMERIC	5	
ATTENDING PHYSICIAN	65	TABLE 1004		
AUTHORIZED SIGNER FOR REPORT	25	FREE TEXT	3	
BRANCH OF SERVICE	116	TABLE 1023	2	
CAUSE INJ BYTE 1	82.5	TABLE 2016	1	FN
CAUSE OF DEATH/SEPARATION	79	TABLE 4001	1	
CAUSE OF INJ CODE	83	TABLE 2009	3	
CAUSE OF INJ TEXT	84	FREE TEXT	41	
CAUSE OF INJ TEXT 2	85	FREE TEXT	79	
CAUSE OF INJ TEXT 3	86	FREE TEXT	79	
CIV HOSP TRANSFERRED TO	68	FREE TEXT	27	
CIVILIAN OCCUPATION	107	FREE TEXT	25	
CONV LEAVE RECOMMENDED	73	NUMERIC	2	FN
CORRECTED RECORD FLAG	28	SET C-CORRECTED	1	
DATE OF INITIAL PROCEDURE	81	DATE	11	N
DATE RECORD LAST EDITED	21	DATE	11	
DAYS ALL MTF 1	206	NUMERIC	3	
DAYS ALL MTF 2	207	NUMERIC	3	
DAYS ALL MTF 3	208	NUMERIC	3	
DAYS ALL MTF 4	209	NUMERIC	3	
DAYS ALL MTF 5	210	NUMERIC	3	
DAYS MTF 1	200	NUMERIC	3	
DAYS MTF 2	201	NUMERIC	3	
DAYS MTF 3	202	NUMERIC	3	
DAYS MTF 4	203	NUMERIC	3	
DAYS MTF 5	204	NUMERIC	3	
DELINQUENCY POSTED DATE	260	DATE	11	
DISC NOTE DICT COMP	236	DATE	11	
DISC NOTE MISSING DICT	235	SET X-MISSING	1	
DISC NOTE MISSING SIG	233	SET X-MISSING	1	
DISC NOTE PRVDR	232	TABLE 1004	6	
DISC NOTE SIG COMP	234	DATE	11	
DISC ORDER DICT COMP	231	DATE	11	
DISC ORDER MISSING DICT	230	SET X-MISSING	1	
DISC ORDER MISSING SIG	228	SET X-MISSING	1	
DISC ORDER PRVDR	227	TABLE 1004	6	
DISC ORDER SIG COMP	229	DATE	11	
DISP CLN SERV	61	TABLE 2005	4	
DISP DATE/TIME	11	DATE	11	
DISP TYPE SCREEN	13	FREE TEXT	4	
DISP TYPE TAPE	14	FREE TEXT	4	
DOB	5	DATE	11	

FILE 7000 - CLINICAL RECORD FILE (Cont'd.)

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
DUTY ADDRESS	117	FREE TEXT	28	
DUTY CITY	118	FREE TEXT	20	
DUTY STATE	119	TABLE 1015	2	
DUTY ZIP	120	FREE TEXT	9	
FLYING STATUS	124	TABLE 1014	2	
FMP	3	TABLE 1012	2	
HIST PHY DICT COMP	238	DATE	11	
HIST PHY MISSING DICT	217	SET X-MISSING	1	
HIST PHY PRVDR	214	TABLE 1004	6	
HIST PHY SIG	215	SET X-MISSING	1	
HIST PHY SIG DATE	216	DATE	11	
INIT ADMIT DATE TAPE	15	DATE	11	
MARITAL STATUS	101	SET	1	
MILITARY OCCUPATION	106	TABLE 1029	4	
MODE TRANSIT OUT	66	SET A-AMBULANCE E-AIR EVAC S-SHIP O-OTHER	1	
MTF TRANSFERRED TO	62	FREE TEXT		
NARR DICT COMP	239	DATE	11	
NARR MISSING DICT	221	SET X-MISSING	1	
NARR MISSING SIG	219	SET X-MISSING	1	
NARR SIG DATE COMP	220	DATE	11	
NARRATIVE PRVDR	218	TABLE 1004	6	
NURSE WARD 2	237.1	TABLE 8010	4	
NURSE WARD 3	237.2	TABLE 8010	4	
NURSE WARD	237	TABLE 8010	4	
OP DICT COMP	226	DATE	11	
OP MISSING DICT	225	SET X-MISSING	1	
OP MISSING SIG	223	SET X-MISSING	1	
OP REPORT PRVDR	222	TABLE 1004	6	
OP SIG DATE	224	DATE	11	
OTHER SIG 1	243	TABLE 1004	6	
OTHER SIG 1 COMP	244	DATE	11	
OTHER SIG 2	245	TABLE 1004	6	
OTHER SIG 2 COMP	246	DATE	11	
OTHER SIG 3	247	TABLE 1004	6	
OTHER SIG 3 COMP	248	DATE	11	
OTHER SIG 4	249	TABLE 1004	6	
OTHER SIG 4 COMP	250	DATE	11	
OTHER SIG 5	251	TABLE 1004	6	
OTHER SIG 5 COMP	252	DATE	11	
OTHER SIG 6	253	TABLE 1004	6	
OTHER SIG 6 COMP	254	DATE	11	
OTHER SIG 7	255	TABLE 1004	6	
OTHER SIG 7 COMP	256	DATE	11	

FILE 7000 - CLINICAL RECORD FILE (Cont'd.)

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
OTHER SIG 8	257	TABLE 1004	6	
OTHER SIG 8 COMP	258	DATE	11	
PATIENT CAT	100	TABLE 1002	3	
PATIENT CITY	109	FREE TEXT	20	
PATIENT HM PHONE	112	FREE TEXT	14	
PATIENT NAME	2	FREE TEXT	27	
PATIENT STATE	110	TABLE 1015	2	
PATIENT STREET	108	FREE TEXT	28	
PATIENT WK PHONE	113	FREE TEXT	14	
PATIENT ZIP	111	FREE TEXT	9	
PAY GRADE	122	FREE TEXT	2	
PHYS ORDERING DISP	12	TABLE 1004	6	
PRES FET2	76	TABLE 4005	2	F
PRES FET3	77	TABLE 4005	2	F
PRES FET4	78	TABLE 4005	2	F
PRESENTATION OF FETUS1	75	TABLE 4005	2	F
PRIMARY MTF	114	TABLE 1005		
RACE	102	TABLE 1024	1	
REASON FOR RELEASE	26	FREE TEXT	35	
REC TRK NOTES 1	241	FREE TEXT	73	
REC TRK NOTES 2	242	FREE TEXT	79	
REC TRK START DATE	212	DATE	11	
RECORD CLERK	20	FREE TEXT	3	
RECORD STATUS	22	SET X-REJECTED R-RELEASED TO A&D I-INCOMPLETE W-WAITING APPROVAL A-APPROVED D-DELETED	1	
RECORD TRACK STATUS	240	TABLE 4013	1	
REGISTER NUMBER	.01	FREE TEXT		
RELIGION	103	TABLE 1000	3	
RESIDUAL DISABILITY	71	FREE TEXT	3	A
FLYING STATUS	105	TABLE 1014	2	
SEX	6	SET M-MALE F-FEMALE Z-UNKNOWN	1	
SOURCE OF ADM SCREEN	7	FREE TEXT	3	
SOURCE OF ADM TAPE	8	FREE TEXT	3	
SPONSOR NAME	115	FREE TEXT	27	
SPONSOR RANK	123	TABLE 1006		
SSN	4	FREE TEXT		
SUSPENSE DATE	213	DATE	11	

FILE 7000 - CLINICAL RECORD FILE (Cont'd.)

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
TAPE DATE	23	DATE	11	
TOT BED DAYS	17	NUMERIC	3	
TOT DAYS THIS MTF (EPI)	18	NUMERIC	3	
TOT NON-BED DAYS	16	NUMERIC	3	
TOT NUM OF EPI RECORDS	19	NUMERIC	3	
TOTAL DAYS IN TRANSIT	259	NUMERIC	3	
TOTAL SICK DAYS ALL MTF	211	NUMERIC	3	
TOTAL SICK DAYS THIS MTF	205	NUMERIC	3	
TRANSFER VA HOSP/AUTOPSY	69	SET V-TRANSFERRED TO VA HOSPITAL A-AUTOPSY PERFORMED ON PATIENT	1	A
TYPE CASE	64	TABLE 2004	3	
UNIT ID	121	FREE TEXT	9	
UNITS WHOLE BLOOD	72	NUMERIC	4	
VOLUME PACKED CELLS	74	NUMERIC	4	
WARD	10	FREE TEXT	3	

FILE 7000.01 - TRANSFER HISTORY SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ABSENT SICK DAYS	5	NUMERIC	3	
ADMIT DATE	2	DATE	11	
BED DAYS	4	NUMERIC	3	
CONV LV DAYS	6	NUMERIC	3	
COOP CARE	10	NUMERIC	3	
DAYS IN TRANSIT	12	NUMERIC	3	
DISPOSITION DATE	3	DATE	11	
LINE NUMBER	9	(for internal use)		
MODE OF TRANSIT	11	SET A-AMBULANCE E-AIR EVAC H-HELICOPTER S-SHIP O-OTHER	1	F
MTF TRANSFERRED FROM	1	FREE TEXT	4	
OTHER DAYS	8	NUMERIC	3	
SUPPLEMENTAL CARE DAYS	7	NUMERIC	3	

FILE 7000.02 - DIAGNOSIS SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
CAUSE INJ	4	TABLE 2009	3	N
CAUSE BYTE 1	3.5	TABLE 2016	1	N
GROUP NUMBER	5	(for internal use)	2	A
ICD1	1	FREE TEXT	6	
ICD1A	2	TABLE 4002		
IDC1B	3	TABLE 4003		
OCCUP RELATED	4.5	SET Y-YES N-NO	1	N
ICD TEXT LINE 1	6	FREE TEXT	70	
ICD TEXT LINE 2	7	FREE TEXT	70	

FILE 7000.03 - PROCEDURE SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ITEM NUMBER	11	(for internal use)	64	
PROCEDURE TEXT LINE 1	9	FREE TEXT	64	
PROCEDURE TEXT LINE 2	10	FREE TEXT		
NUMBER OF OCCURRENCES OF PROCD	3	NUMERIC		
PROCEDURE CODE	1	TABLE PRC	4	
PROCEDURE START DATE	4	DATE		
PROCEDURE STOP DATE	5	DATE		
PROVIDER1	6	TABLE 1004		
PROVIDER2	7	TABLE 1004		
PROVIDER3	8	TABLE 1004		
WHERE PROCEDURE PERFORMED	2	TABLE 4009		

FILE 7000.04 - NON-PROCEDURAL PROVIDERS SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
NON PROC PROVIDERS	.01	TABLE 1004		
NPP2	2	TABLE 1004		
NPP3	3	TABLE 1004		

FILE 7000.05 - EPISODE DAYS SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ABSENT STATUS	3	TABLE 2002		
BEDDAYS	5	NUMERIC	3	
CLINICAL SVC	2	TABLE 2005		
DAYS	4	NUMERIC	3	
EPISODE EFFECT DATE	1	DATE		
NON-BED DAYS	6	NUMERIC	3	
TOTAL DISPLAY	7	FREE TEXT	6	

FILE 7000.06 - ADMINISTRATIVE TEXT SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
LONG LINE	2	FREE TEXT	73	
SHORT LINE	1	FREE TEXT	50	

FILE 7000.07 - CLERK UPDATE TRACE SUBFILE (CR)

FIELD DESCRIPTION	FIELD NUMBER	TYPE		LENGTH	MIL DEP SPEC
CLERK ACTION	3	SET	X-REJECTED O-OVERRIDE A-APPROVE D-DELETE R-RELEASE	1	
CLERKS INITIALS	1	FREE	TEXT	3	
UPD DATE/TIME	2	DATE			

FILE 6030 - PROVIDER PROFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ANTIBIOTIC VAR	30	NUMERIC	6	
ANTIBIOTIC VAR 2	50	NUMERIC	6	
ANTIBIOTIC VAR 3	62	NUMERIC	6	
ANTIBIOTIC VAR 4	74	NUMERIC	6	
ANTIBIOTIC VAR 5	86	NUMERIC	6	
ANTIBIOTIC VAR 6	98	NUMERIC	6	
ANTIBIOTIC VAR 7	110	NUMERIC	6	
CAL YEAR 1	32	NUMERIC	2	
CAL YEAR 2	34	NUMERIC	2	
CAL YEAR 3	36	NUMERIC	2	
CLERK TRACE	20	DATE		
CONTINUING ED HR 1	33	NUMERIC	3	
CONTINUING ED HR 2	35	NUMERIC	3	
CONTINUING ED HR 3	37	NUMERIC	3	
DATE ACLS CERT	3	DATE		
DATE ATLS CERT	4	DATE		
DATE CPR TRAINING	2	DATE		
DATE CRED RENEWAL	5	DATE		
DATE LICENSE RENEWAL	6	DATE		
DEATH	39	NUMERIC	6	
DEATHS 2	52	NUMERIC	6	
DEATHS 3	64	NUMERIC	6	
DEATHS 4	76	NUMERIC	6	
DEATHS 5	88	NUMERIC	6	
DEATHS 6	100	NUMERIC	6	
DEATHS 7	112	NUMERIC	6	
MALPRACTICE CLAIMS FIELD	26	NUMERIC	6	
MALPRACTICE CLAIMS FIELD 2	46	NUMERIC	6	
MALPRACTICE CLAIMS FIELD 3	58	NUMERIC	6	
MALPRACTICE CLAIMS FIELD 4	70	NUMERIC	6	
MALPRACTICE CLAIMS FIELD 5	82	NUMERIC	6	
MALPRACTICE CLAIMS FIELD 6	94	NUMERIC	6	
MALPRACTICE CLAIMS FIELD 7	106	NUMERIC	6	
MED REC DEFICIENCIES	28	NUMERIC	6	
MED REC DEFICIENCIES 2	48	NUMERIC	6	
MED REC DEFICIENCIES 3	60	NUMERIC	6	
MED REC DEFICIENCIES 4	72	NUMERIC	6	
MED REC DEFICIENCIES 5	84	NUMERIC	6	
MED REC DEFICIENCIES 6	96	NUMERIC	6	
MED REC DEFICIENCIES 7	108	NUMERIC	6	
MED REC DELINQUENCIES	24	NUMERIC	6	
MED REC DELINQUENCIES 2	44	NUMERIC	6	
MED REC DELINQUENCIES 3	56	NUMERIC	6	
MED REC DELINQUENCIES 4	68	NUMERIC	6	
MED REC DELINQUENCIES 5	80	NUMERIC	6	

FILE 6030 - PROVIDER PROFILE (Cont'd.)

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
MED REC DELINQUENCIES 6	92	NUMERIC	6	
MED REC DELINQUENCIES 7	104	NUMERIC	6	
MTF ASSIGNMENT DATE	8	NUMERIC		
PATIENTS DISCHARGED	22	NUMERIC	6	
PATIENTS DISCHARGED 2	42	NUMERIC	6	
PATIENTS DISCHARGED 3	54	NUMERIC	6	
PATIENTS DISCHARGED 4	66	NUMERIC	6	
PATIENTS DISCHARGED 5	78	NUMERIC	6	
PATIENTS DISCHARGED 6	90	NUMERIC	6	
PATIENTS DISCHARGED 7	102	NUMERIC	6	
POSTING DATE	40	DATE		
POSTING DATE 2	41	DATE		
POSTING DATE 3	53	DATE		
POSTING DATE 4	65	DATE		
POSTING DATE 5	77	DATE		
POSTING DATE 6	89	DATE		
POSTING DATE 7	101	DATE		
PROCEDURES PERFORMED	23	NUMERIC	6	
PROCEDURES PERFORMED 2	43	NUMERIC	6	
PROCEDURES PERFORMED 3	55	NUMERIC	6	
PROCEDURES PERFORMED 4	67	NUMERIC	6	
PROCEDURES PERFORMED 5	79	NUMERIC	6	
PROCEDURES PERFORMED 6	91	NUMERIC	6	
PROCEDURES PERFORMED 7	103	NUMERIC	6	
PROVIDER ID	.01	TABLE 1004		
QA ID CODE	38	NUMERIC	9	
SCRAMBLED SSN	9	FREE TEXT		
STATE OF LICENSE	7	TABLE 1005	2	
SURG PNT NORM TISS	29	NUMERIC	6	
SURG PNT NORM TISS 2	49	NUMERIC	6	
SURG PNT NORM TISS 3	61	NUMERIC	6	
SURG PNT NORM TISS 4	73	NUMERIC	6	
SURG PNT NORM TISS 5	85	NUMERIC	6	
SURG PNT NORM TISS 6	97	NUMERIC	6	
SURG PNT NORM TISS 7	109	NUMERIC	6	
TRANSFUSION VARIATIONS	31	NUMERIC	6	
TRANSFUSION VARIATIONS 2	51	NUMERIC	6	
TRANSFUSION VARIATIONS 3	63	NUMERIC	6	
TRANSFUSION VARIATIONS 4	75	NUMERIC	6	
TRANSFUSION VARIATIONS 5	87	NUMERIC	6	
TRANSFUSION VARIATIONS 6	99	NUMERIC	6	
TRANSFUSION VARIATIONS 7	111	NUMERIC	6	
VALIDATED OS VARIATIONS	25	NUMERIC	6	
VALIDATED OS VARIATIONS 2	45	NUMERIC	6	
VALIDATED OS VARIATIONS 3	57	NUMERIC	6	
VALIDATED OS VARIATIONS 4	69	NUMERIC	6	

FILE 6030 - PROVIDER PROFILE (Cont'd.)

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
VALIDATED OS VARIATIONS 5	81	NUMERIC	6	
VALIDATED OS VARIATIONS 6	93	NUMERIC	6	
VALIDATED OS VARIATIONS 7	105	NUMERIC	6	
VALIDATED PNT COMPLAINTS	27	NUMERIC	6	
VALIDATED PNT COMPLAINTS 2	47	NUMERIC	6	
VALIDATED PNT COMPLAINTS 3	59	NUMERIC	6	
VALIDATED PNT COMPLAINTS 4	71	NUMERIC	6	
VALIDATED PNT COMPLAINTS 5	83	NUMERIC	6	
VALIDATED PNT COMPLAINTS 6	95	NUMERIC	6	
VALIDATED PNT COMPLAINTS 7	107	NUMERIC	6	

FILE 6030.01 - PROVIDER PROFILE CLERK TRACE SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
CLERK INITIALS	1	FREE TEXT	3	
CLERK TRACE	.01	DATE		

FILE 6010 - INCIDENT FILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ACTION CODE 1-1	16	TABLE 6054		
ACTION CODE 1-2	17	SET 1-PROVIDER RELATED 2-NOT PROVIDER RELATED	1	
ACTION CODE 1-3	18	TABLE 6055		
ACTION CODE 1-4	19	SET Y-ENTERED INTO PROFILE N-NOT ENTER INTO PROFILE	1	
ACTION CODE 2-1	20	TABLE 6054		
ACTION CODE 2-2	21	SET 1-PROVIDER RELATED 2-NOT PROVIDER RELATED	1	
ACTION CODE 2-3	22	TABLE 6055		
ACTION CODE 2-4	23	SET Y-ENTERED INTO PROFILE N-NOT ENTER INTO PROFILE	1	
ACTION CODE 3-1	25	TABLE 6054		
ACTION CODE 3-2	26	SET 1-PROVIDER RELATED 2-NOT PROVIDER PROFILE	1	
ACTION CODE 3-3	27	TABLE 6055		
ACTION CODE 3-4	28	SET Y-ENTERED INTO PROFILE N-NOT ENTER INTO PROFILE	1	
DATE ACTION 1	15	DATE		
DATE ACTION 2	19.5	DATE		
DATE ACTION 3	24	DATE		
DATE JAG REVIEW	12	DATE		
DATE/TIME OF INCIDENT	1	DATE		
INCIDENT LOCATION	8	FREE TEXT		
INCIDENT LOG NO	.01	FREE TEXT		
INCIDENT PERSON TYPE	2	FREE TEXT	15	
INCIDENT RESULT	11	SET Y-INJURY N-NO INJURY	1	
INCIDENT TYPE	7	FREE TEXT	20	
JAG REVIEW	13	SET Y-YES N-NO	1	
PERSON EMP	4	TABLE 1012		
PERSON NAME	3	FREE TEXT	27	
PERSON REG NO	6	FREE TEXT	8	
PERSON SSN	5	FREE TEXT		
PERSONNEL INVOLVED	9	FREE TEXT	15	
PERSONNEL REPORTING	10	FREE TEXT	15	

FILE 6010.01 - INCIDENT CLERK TRACE SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
CLERK INITIALS	1	FREE TEXT	3	
DATE/TIME UPDATED	.01	DATE		

FILE 6020 - PROBLEM FILE (QA)

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
DATE PRESENTED	2	DATE		
IMPACT 1	8	FREE TEXT	79	
IMPACT 2	9	FREE TEXT	79	
PROBLEM NO	.01	FREE TEXT		
REFERRAL ACTIVITY	3	FREE TEXT	15	
RESOLVE FLAG	12	SET Y-YES N-NO	1	

FILE 6020.01 - PROBLEM CLERK TRACE SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
CLERK INITIALS	1	FREE TEXT	3	
CLERK TRACE	.01	DATE		

FILE 6020.02 - PROBLEM HISTORY SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ACTION ACTIVITY	1	FREE TEXT	15	
ACTION TAKEN	2	FREE TEXT	79	
FOLLOWUP DATE	3	DATE		
STATUS DATE	.01	DATE		

FILE 6000 - INPATIENT OCCURRENCE SCREENING CHECKLIST

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
CR APPROVED FLAG	32	SET A-APPROVED	1	
DISCHARGE DATE	2	DATE		
FMP	3	FREE TEXT	2	
PROVIDER PRIMARY	1	TABLE 1004		
PROVIDER SPECIALTY	34	FREE TEXT	4	
Q01	5	SET Y-YES N-NO	1	
Q02	6	SET Y-YES N-NO	1	
Q03	7	SET Y-YES N-NO	1	
Q04	8	SET Y-YES N-NO	1	
Q05	9	SET Y-YES N-NO	1	
Q06	10	SET Y-YES N-NO	1	
Q07	11	SET Y-YES N-NO	1	
Q08	12	SET Y-YES N-NO	1	
Q09	13	SET Y-YES N-NO	1	
Q10	14	SET Y-YES N-NO	1	
Q11	15	SET Y-YES N-NO	1	
Q12	16	SET Y-YES N-NO	1	
Q13	17	SET Y-YES N-NO	1	
Q14	18	SET Y-YES N-NO	1	
Q15	19	SET Y-YES N-NO	1	
Q16	20	SET Y-YES N-NO	1	
Q17	21	SET Y-YES N-NO	1	
Q18	22	SET Y-YES N-NO	1	
Q19	23	SET Y-YES N-NO	1	
Q20	24	SET Y-YES N-NO	1	
Q21	25	SET Y-YES N-NO	1	
Q22	26	SET Y-YES N-NO	1	
Q23	27	SET Y-YES N-NO	1	
Q24	28	SET Y-YES N-NO	1	
REGISTER NO	.01	FREE TEXT		
SSN	4	NUMERIC		
YES STRING FOR PULL	33	FREE TEXT		

FILE 6000.01 - IP OS AUDIT SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ACTION CODE 1-1	4	TABLE 6054		
ACTION CODE 1-2	5	SET 1 - PROVIDER RELATED SET 2 - NOT PROVIDER RELATED	1	
ACTION CODE 1-3	6	TABLE 6055		
ACTION CODE 1-4	7	SET Y - ENTERED INTO PROFILE N - NOT ENTERED INTO PROFILE	1	
ACTION CODE 2-1	11	TABLE 6054		
ACTION CODE 2-2	12	SET 1 - PROVIDER RELATED SET 2 - NOT PROVIDER RELATED	1	
ACTION CODE 2-3	13	TABLE 6055		
ACTION CODE 2-4	14	SET Y - ENTERED INTO PROFILE SET N - NOT ENTERED INTO PROFILE	1	
ACTION CODE 3-1	18	TABLE 6054		
ACTION CODE 3-2	19	SET 1 - PROVIDER RELATED SET 2 - NOT PROVIDER RELATED		
ACTION CODE 3-3	20	TABLE 6055		
ACTION CODE 3-4	21	SET Y - ENTERED INTO PROFILE SET N - NOT ENTERED INTO PROFILE	1	
AUDIT SUBFILE	.01	(For internal use)		
DATE DUE 1	2	DATE		
DATE DUE 2	9	DATE		
DATE DUE 3	16	DATE		
DATE IN 1	3	DATE		
DATE IN 2	10	DATE		
DATE IN 3	17	DATE		
DATE OUT 1	1	DATE		
DATE OUT 2	8	DATE		
DATE OUT 3	15	DATE		
PROVIDER-1	30	TABLE 1004		
PROVIDER-2	31	TABLE 1004		
PROVIDER-3	32	TABLE 1004		
PROVIDER-4	33	TABLE 1004		
PROVIDER-5	34	TABLE 1004		

FILE 6000.02 - IP OS CLERK EDIT SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
CLERK EDIT SUBFILE	.01	DATE		
CLERK INITIALS	2	FREE TEXT	3	
DATETIME IDX	.001	(For internal use)		

FILE A001 - EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
DATE/TIME OF TREATMENT	4	DATE		
DEFAULT QUESTION 1	27	FREE TEXT	1	
ER LOB NBR	.001	(for internal use)		
ER LOG NUMBER	.01	NUMERIC		
FILLER1	2	FREE TEXT	99	
FILLER2	3	FREE TEXT	99	
PROVIDER	5	TABLE 1004	1	
Q01	6	SET Y-YES N-NO	1	
Q02	7	SET Y-YES N-NO	1	
Q03	8	SET Y-YES N-NO	1	
Q04	9	SET Y-YES N-NO	1	
Q05	10	SET Y-YES N-NO	1	
Q06	11	SET Y-YES N-NO	1	
Q07	12	SET Y-YES N-NO	1	
Q08	13	SET Y-YES N-NO	1	
Q09	14	SET Y-YES N-NO	1	
Q10	15	SET Y-YES N-NO	1	
Q11	16	SET Y-YES N-NO	1	
Q12	17	SET Y-YES N-NO	1	
Q13	18	SET Y-YES N-NO	1	
Q14	19	SET Y-YES N-NO	1	
Q15	20	SET Y-YES N-NO	1	
Q16	21	SET Y-YES N-NO	1	
Q17	22	SET Y-YES N-NO	1	
Q18	23	SET Y-YES N-NO	1	

FILE 6001.01 - ER OS AUDIT SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ACTION CODE 1-1	4	TABLE 6054		
ACTION CODE 1-2	5	SET 1 - PROVIDER RELATED SET 2 - NOT PROVIDER RELATED	1	
ACTION CODE 1-3	6	TABLE 6055		
ACTION CODE 1-4	7	SET Y - ENTERED INTO PROFILE N - NOT ENTERED INTO PROFILE	1	
ACTION CODE 2-1	11	TABLE 6054		
ACTION CODE 2-2	12	SET 1 - PROVIDER RELATED SET 2 - NOT PROVIDER RELATED	1	
ACTION CODE 2-3	13	TABLE 6055		
ACTION CODE 2-4	14	SET Y - ENTERED INTO PROFILE SET N - NOT ENTERED INTO PROFILE	1	
ACTION CODE 3-1	18	TABLE 6054		
ACTION CODE 3-2	19	SET 1 - PROVIDER RELATED SET 2 - NOT PROVIDER RELATED		
ACTION CODE 3-3	20	TABLE 6055		
ACTION CODE 3-4	21	SET Y - ENTERED INTO PROFILE SET N - NOT ENTERED INTO PROFILE	1	
AUDIT SUBFILE	.01	NUMERIC		
DATE DUE 1	2	DATE		
DATE DUE 2	9	DATE		
DATE DUE 3	16	DATE		
DATE IN 1	3	DATE		
DATE IN 2	10	DATE		
DATE IN 3	17	DATE		
DATE OUT 1	1	DATE		
DATE OUT 2	8	DATE		
DATE OUT 3	15	DATE		
PROVIDER-1	30	TABLE 1004		
PROVIDER-2	31	TABLE 1004		
PROVIDER-3	32	TABLE 1004		
PROVIDER-4	33	TABLE 1004		
PROVIDER-5	34	TABLE 1004		

FILE 6001.02 - ER OS CLERK TRACE SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
CLERK	.01	DATE		
CLERK INITIALS	1	FREE TEXT	3	

FILE 6005 - EMERGENCY TOP LEVEL FILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
FMP	2	TABLE 1012		
NAME	.01	FREE TEXT	27	
SSN	3	FREE TEXT	11	

FILE 6005.01 - ER LOG NO. SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ER LOG NUMBER	.01	NUMERIC		
YES LIST FOR PULL	2	FREE TEXT	60	

FILE 1004 - DOCTOR FILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
AF ID CODE	2	FREE TEXT	6	F
DATE ASSIGNED TO MTF	1.4	DATE		
DELETE DATE	10	DATE		
DOCTOR NAME	1	FREE TEXT	30	
PRIM CARE PROVIDER CODE	.01	FREE TEXT	6	
SPECIALTY	1.5	FREE TEXT	30	
SSN	1.2	FREE TEXT		

FILE 8010 ~ WARD FILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
DELETE DATE	7	DATE		
OTHER BEDS BLOCKED	5	NUMERIC	3	
TOTAL BEDS	3	NUMERIC	3	
TOTAL BEDS OCCUPIED	6	NUMERIC	3	
TOTAL PREADMITS	4	NUMERIC	3	
WARD DESCRIPTION	2	FREE TEXT	30	
WARD ID	.01	FREE TEXT	4	

FILE 8020.99 - A&D EVENT SUBFILE

FIELD DESCRIPTION	FIELD NUMBER	TYPE	LENGTH	MIL DEP SPEC
ABSENT STATUS	.03	TABLE 2002		
CLERKS INITS	.09	FREE TEXT	3	
CLINICAL SERVICE	.04	TABLE 2005		
CURRENT DT/TIME	.08	DATE		
EFF DT/TIME	.001	DATE		
EFFDTTM	.01	DATE		
INDICATOR	.02	(For internal use)		
NEW WARD	.06	TABLE 8010		
OLD WARD	.05	TABLE 8010		
TEXT	.07	FREE TEXT	72	

Appendix H

ERROR CODES

ERROR (table) LIST SEP 4,1985 14:41 PAGE 1

MESSAGE CODE	MESSAGE	PROGRAM NAME
1	INVALID ENTRY	SYMFLG SYTM1
2	REQUIRED FIELD	
3	SPONSOR'S NAME MUST BE ENTERED	RGC1
900	INVALID USER ID-PASSWORD COMBINATION	SO
901	TERMINAL CAPABILITIES UNDEFINED	SO
902	UNAUTHORIZED SELECTION	SO
903	YOUR TERMINAL IS LOCKED - SEE YOUR SYSTEM MANAGER	SO
904	YOUR USER ID IS LOCKED - SEE YOUR SYSTEM MANAGER	SO
905	*No extended explanation for this error.*	TUCD
1001	PATIENT CATEGORY AND FMP INCONSISTENT	RGC CMADC
1002	PATIENT CATEGORY AND AGE INCONSISTENT	RGC CMADC
1003	PATIENT'S SEX AND FMP ARE INCONSISTENT	RGC
1004	MARITAL STATUS INCONSISTENT WITH FMP AND/OR PATIENT CATEGORY	RGC
1005	AFSC/MOS REQUIRED FOR ACTIVE DUTY AIR FORCE/ARMY	RGC
1006	AVIATION SERVICE CODE IS ONLY ENTERED FOR ACTIVE DUTY PERSONNEL	RGC
1007	PATIENT NAME AND SPONSOR NAME DO NOT MATCH	RGC1
1008	RANK MUST BE ENTERED FOR MILITARY MEMBERS	RGC1
1009	MAJOR COMMAND IS REQUIRED FOR ACTIVE DUTY AIR FORCE	RGC1
1010	FLYING STATUS IS ONLY ENTERED FOR ACTIVE NAVY AND MARINE	RGC1
1011	AERO RATING REQUIRED	RGC1
1012	ONE OF THE COMMAND INTEREST MUST BE 'VIP'	RGC2
1013	UNIT ID CODE REQUIRED	RGC2
1014	MILITARY SPECIALTY REQUIRED	RGC2
1015	MILITARY SPECIALTY MUST BE NUMERIC	RGC2
1016	MILITARY SPECIALTY CANNOT BE NUMERIC	RGC2
1017	ID CARD NUMBER MUST BE BLANK FOR ACTIVE DUTY AND RETIRED PATIENTS	RGC2
1018	RANK AND PATIENT CATEGORY INCONSISTENT	RGC1 RGC2
1019	RANK AND PAY GRADE INCONSISTENT	
1020	PATIENT ADDRESS REQUIRED	RGC2
1021	MILITARY ADDRESS REQUIRED	RGC2
1022	ONE OF THE COMMAND INTEREST FIELDS MUST BE CODED 'STF'	RGC2
1023	ARMY BRANCH OF SERVICE REQUIRED FOR THIS PATIENT CATEGORY	RGC1
1024	BRANCH OF SERVICE INVALID FOR THIS PATIENT CATEGORY	RGC1
1025	SERVICE REQUIRED FOR FOREIGN MILITARY	RGC1
1026	SERVICE MUST BE ENTERED FOR THIS PATIENT	RGC1
1027	SOCIAL SECURITY NUMBER IS REQUIRED	RGC
1028	EPISODE FOR THIS REGISTER NUMBER IS NO LONGER CURRENT	AT
1029	MILITARY AFSC/MOS CANNOT BE ENTERED FOR THIS PATIENT CATEGORY AND/OR RANK	RGC2 RGC
1030	THIS REGISTER NUMBER IS NOT THE MOST RECENT EPISODE FOR THE PATIENT	DS
1100	PATIENT'S STREET ADDRESS REQUIRED	
1101	PATIENT'S CITY ADDRESS REQUIRED	
1102	PATIENT'S STATE ADDRESS REQUIRED	
1103	Patient ZIP CODE required for non-active duty PNT CAT	RGC1 RGC2
1104	PATIENT CATEGORY REQUIRED	
1105	PATIENT'S MILITARY SPECIALTY REQUIRED	
1106	SPONSOR'S RANK REQUIRED	
1107	SPONSOR'S BRANCH OF SERVICE REQUIRED	
1108	SPONSOR'S DUTY ADDRESS REQUIRED	RGC2
1109	SPONSOR'S CITY ADDRESS REQUIRED	RGC2
1110	SPONSOR'S STATE ADDRESS REQUIRED	RGC2
1111	SPONSOR'S ZIP CODE REQUIRED	RGC1 RGC2

MESSAGE CODE	MESSAGE	PROGRAM NAME
1120	FIELD 'SEX' UNANSWERED	RGVC
1121	FIELD 'RACE' UNANSWERED	RGVC
1122	ID CARD EXPIRATION DATE REQUIRED	RGVC
1123	UNIT ID REQUIRED	RGVC
1130	HOME PHONE NUMBER REQUIRED	
1131	WORK PHONE NUMBER REQUIRED	
1132	CIVILIAN OCCUPATION REQUIRED	
1140	HOME STATE REQUIRED	
1141	MARITAL STATUS REQUIRED	
1142	RELIGION REQUIRED	
1143	PRIMARY CARE PROVIDER REQUIRED	
1144	FLYING STATUS REQUIRED	RGC1
1150	PRIMARY MTF REQUIRED	
1201	NO WARDS ARE BEING DEFINED	
1202	INVALID WARD ID	
1203	WARD ALREADY EXISTS	
1204	INVALID WARD ID/SELECTION	
1205	ARE YOU SURE YOU WANT TO DELETE?	
1206	CANNOT DELETE WARD - WARD NOT EMPTY	
1207	WARD DOES NOT EXIST	
1208	WARD HAS BEEN DELETED	
1209	BEDS IN USE EXCEED TOTAL BEDS	
1210	DO YOU WANT TO FILE RECORD?	
1211	WARD STATUS RECORD IS NOT AVAILABLE	
1213	INVALID SELECTION, STORE OR CANCEL THIS ENTRY	BM QAPNXT
1301	THIS REGISTER NUMBER IS NOT ASSIGNED TO A PATIENT	
1302	THIS RECORD IS UNDER CONTROL OF CLINICAL RECORDS	AT
1303	THIS RECORD IS ARCHIVED	CR
1304	CANNOT EDIT WHEN PREVIOUS DATA WAS 'CRO' OR 'P/S'	CMSRC
1305	CANNOT USE 'CRO' OR 'P/S' IN CORRECTION MANAGEMENT	CMSRC
1306	CANNOT ENTER THE DATE WITHOUT THE TYPE OR SOURCE	CMDISP
1307	CANNOT DISPOSITION A PATIENT IN THE CM FUNCTION	CMDISP CMSRC
1308	CANNOT CANCEL ADMISSION IN CM	CMSRC
1309	CANNOT CHANGE THE SOURCE OF ADM WHEN IT IS A CANCEL	
1310	YOU MUST USE THE NEXT BLANK LINE TO ADD A NEW RECORD	CMH CMT
1311	THE A&D REPORT DATE MUST BE TODAY	CMT
1312	ADMISSION DATE CANNOT BE CHANGED ON THIS SCREEN	CMEFDT
1313	DISPOSITION DATE CANNOT BE CHANGED ON THIS SCREEN	CMEFDT
1314	THIS EVENT DATE/TIME IS PRIOR TO ADMISSION DATE/TIME	CMTC CMEFDT
1315	THIS EVENT DATE/TIME IS AFTER THE DISPOSITION DATE	CMTC CMEFDT
1316	YOU MUST ENTER A TIME. FORMAT IS DATE@TIME	CMEFDT
1317	YOU CANNOT DELETE AN ADMISSION OR A DISPOSITION EVENT	CMH
1318	CLINICAL SERVICE CODE MUST BE CRO	
1320	ONLY THE ADMIT CLN SRV CAN BE ERD OR CRO	CMCSRV
1322	ERD OR CRO DATA CANNOT BE CHANGED	CMCSRV
1323	CANNOT CHANGED THE SOURCE OF ADMISSION WHEN IT IS QUARTERS	CMSRC
1325	CANNOT CHANGE THE SOURCE OF ADMISSION WHEN IT IS ABSENT SICK	CMSRC
1330	CLINICAL SERVICE IS REQUIRED	CMFIL
1332	THE CLINICAL SERVICE CANNOT BE BLANK	CMFIL
1334	YOU CANNOT DELETE DATA FROM THE DISPOSITION RECORD	CMFIL
1335	THE ABSENT STATUS CANNOT BE BLANK	CMFIL
1336	THE NEW WARD ASSIGNMENT CANNOT BE BLANK	CMFIL
1337	THE OLD WARD ASSIGNMENT CANNOT BE BLANK	CMFIL

MESSAGE CODE	MESSAGE	PROGRAM NAME
1338	BOTH NEW AND OLD WARDS ARE REQUIRED FOR AN INTER-WARD TRANSFER	CMFIL
1339	FOR AN INTERWARD TRANSFER WARDS MUST NOT BE EQUAL	CMFIL
1340	THE ADMIT EVENT CANNOT CONTAIN OLD WARD	CMFIL
1350	ADMIT DATE IS AFTER THE FIRST EVENT DATE	CMADC
1353	SOURCE OF ADM IS NOT NEWBORN - DELETE MOM'S REG NUMBER	CMADC
1354	SOURCE OF ADM IS CRO/ERD - ADM & DISP DATES MUST EQUAL	
1356	SOURCE OF ADM IS CRO/ERD - CURRENT DISP CODE IS NOT VALID	
1360	SOURCE OF ADM IS TRANSFER - TRANSFER IN DATA IS MISSING	CMADC
1362	PATIENT IS DISPOSITIONED - DISP DATE AND TYPE ARE REQUIRED	
1364	DISPOSITION DATE CANNOT BE LESS THAN DATE OF ADMISSION	
1366	DISPOSITION DATE IS BEFORE THE LAST EVENT DATE	
1368	PATIENT CATEGORY IS ACTIVE DUTY - THIS DISP TYPE IS NOT VALID	
1370	DISPOSITION TYPE IS TRANSFER - DISP MTF IS REQUIRED	
1371	TWO CONSECUTIVE AND EQUAL CLINICAL SERVICES	CMHC
1373	OLD WARD MUST EQUAL THE PREVIOUS WARD ASSIGNMENT	CMHC
1379	ABSENT STATUS MISSING FROM CRO/ERD EVENT	CMHC
1380	PATIENT CATEGORY AND ABSENT STATUS ARE INCONSISTENT	CMHC
1381	1ST ABS STA IS BLANK - 2ND EVENT MUST BE ABS STA	CMHC
1382	YOU CANNOT ENTER A FUTURE DATE	CMTC
		CMEFDT
1384	PATIENT NOT DISPOSITIONED - USE TRANSFER TO ADD AN EVENT RECORD	CMH
1385	WHEN SOURCE OF ADM IS CRO OR ERD THERE CANNOT BE EVENT RECORDS	CMHC
1386	CLN SRV OR ABS STA IN 1ST EVENT IS INCONSISTENT WITH ADM SOURCE	CMHC
1387	NEW WARD IS MISSING FROM THE ADMISSION EVENT RECORD	CMHC
1388	WHEN 1ST ABS STA IS BLANK, 2ND MUST BE LOSS	CMHC
1389	INCONSISTENT ABS STA, CLN SRV, OR ADM SOURCE	CMHC
1390	ABSENT SICK IS ONLY VALID FOR THE 2ND EVENT	CMHC
1391	ABS STA IS A LOSS/BED DAY - CANNOT ENTER WARDS	CMHC
1392	ABS STA IS LOSS - OLD WARD REQ'D, NEW MUST BE BLANK	CMHC
1393	RETURNING FROM PASS - MUST USE CURRENT WARD	CMHC
1394	ABS STA IS GAIN - NEW WARD REQ'D, OLD MUST BE BLANK	CMHC
1395	THE ADMIT RECORD AND RETAINED RECORD MUST MATCH	CMHC
1399	DEBUG MESSAGE - CANNOT FIND THE ADMIT EVENT RECORD	CMSRC
1400	SOURCE ADMISSION CAN ONLY BE CHANGED FROM NEWBORN TO RETAINED	ATC
1401	SOURCE ADMISSION CAN'T BE CHANGED FROM PREADMISSION TO RETAINED	
1402	SOURCE OF ADMISSION CAN ONLY BE CHANGED TO CANCEL(ON CANCEL SCREEN)	AT8C
		ATC
1403	NON-MILITARY PATIENTS CAN NOT BE BATTLEFIELD CAUSALTIES	ATC
1404	LENGTH OF SERVICE CAN'T BE ENTERED FOR NON-MILITARY PERSONNEL	ATC
		CMADC
1405	MEB CANDIDATE CANNOT BE ENTERED IF PATIENT IS NOT ACTIVE DUTY	AT7C
		ATC
1406	ABSENT STATUS MUST BE NON-MILITARY	AT5C
		ATC
1407	SOURCE ADMISSION MUST BE NON-MILITARY	ATC
		CMADC
1408	CLINICAL SERVICE MUST BE NON-MILITARY	ATC
1409	LENGTH OF SERVICE REQUIRED FOR MILITARY PERSONNEL	ATC
		CMADC
1410	SOURCE ADMISSION DOES NOT AGREE WITH CLINICAL SERVICE	ATC
1411	CLINICAL SERVICE DOES NOT AGREE WITH ABSENT STATUS	AT5C
		ATC
1412	MEDICAL HOLDING IS ONLY ENTERED FOR ACTIVE DUTY PERSONNEL	ATC1
1413	REGISTER NUMBER MUST BE A NUMBER LESS THAN 9000000	ATRW
		ATC1
1414	EXPIRED TRM SERVICE DATE MUST BE ENTERED FOR ACTIVE DUTY PERSONNEL	ATC1
1415	EXPIRED TRM SERVICE DATE IS ONLY ENTERED FOR ACTIVE DUTY PERSONNEL	ATC1
1416	EAOS/ETS DATE INDICATES PATIENT INELIGIBLE FOR TREATMENT	ATC2

MESSAGE CODE	MESSAGE	PROGRAM NAME
1417	THE MEAL CARD CAN ONLY BE ENTERED FOR ACTIVE DUTY MILITARY	ATC1
1418	ABSENT STATUS MUST BE 'BO' FOR CASUALTY STATUS OF SC, III, SI OR VSI	AT6C
		ATCO
		AT5C
1420	THE MEAL CARD MUST BE ENTERED FOR ENLISTED ACTIVE DUTY MILITARY	ATC1
1421	CLINICAL SERVICE FOR PATIENT OVER 17 YEARS OLD CAN NOT BE PEDIATRICS	ATC1
1422	CLINICAL SERVICE FOR PATIENT OVER 20 YEARS OLD CAN'T BE PEDIATRICS	ATC1
1423	TYPE CASE CANNOT BE BATTLEFIELD CASAULTY IF NOT AT WAR	ATC1
1424	PROJECTED DISPOSITION DATE CAN NOT BE EARLIER THAN ADMISSION DATE	ATEC
1425	ACTIVE INPATIENT - WARD AND ATTENDING PHYSICIAN MUST BE ASSIGNED	AT5C
		ATCO
1426	CLINICAL SERVICE AND PATIENT CATEGORY INCONSISTENT	ATC
		CMCSRV
1427	PATIENT MUST BE FEMALE FOR LABOR/DELIVERY AND GYNECOLOGY	ATC
		CMCSRV
1428	CASUALTY STATUS INVALID FOR INITIAL ADMISSION	ATC
		AT6C
1430	REGISTER NUMBER SUFFIX MUST BE ENTERED FOR NEWBORN	ATC1
1431	REGISTER NUMBER SUFFIX CAN ONLY BE ENTERED FOR NEWBORNS	ATC1
1432	SOURCE ADMISSION NEWBORN IS ONLY FOR DEPENDENTS	ATCO
1433	MOTHER IS NOT A CURRENT INPATIENT	AT1C
1434	MOTHER'S REGISTER NUMBER REQUIRED	AT1C
		CMADC
1435	NO PATIENT ON FILE WITH MOTHER'S REGISTER NUMBER	AT1C
1436	MOTHER MUST BE FEMALE	AT1C
1437	MOTHER'S SSN MUST BE THE SAME AS BABY'S SSN	AT1C
1438	CAN'T CHANGE EFFECTIVE DATE AND TIME WITHOUT CHANGING ABSENT STATUS	AT5C
1439	CAN'T CHANGE ABSENT STATUS WITHOUT CHANGING EFFECTIVE DATE AND TIME	AT5C
1440	NEW EFFECTIVE DATE/TIME MUST BE AFTER PREVIOUS EFFECTIVE DATE/TIME	AT5C
1441	WARD IS NOT CONSISTENT WITH CLINICAL SERVICE	ATC2
1442	AGE MINUS LENGTH OF SERVICE LESS THAN 18 YEARS	ATC2
		CMADC
1443	ABSENT STATUS REQUIRED FOR OTHER THAN PREADMIT	AT5C
		ATCO
1444	RETURN DATE/TIME MUST BE ENTERED	AT5C
1445	RETURN DATE/TIME NOT ALLOWED FOR BED OCCUPANT	AT5C
1446	RETURN DATE/TIME CAN'T BE LESS THAN EFFECTIVE DATE/TIME	AT5C
1447	ABSENT SICK REQUIRES NON-MILITARY HOSPITAL DATA	AT5C
1448	ABSENT STATUS CAN ONLY CHANGE 'IN' TO 'OUT' OR 'OUT' TO 'IN'	AT5C
		ATCO
		ATC2
		CMHC
1449	PATIENT CAN NOT RETURN FROM THIS ABSENT STATUS.	AT5C
		ATC1
1450	IF ABSENT STATUS ENTERED, EFFECTIVE DATE/TIME MUST BE ENTERED	AT5C
1451	MEB DATA CAN'T BE ENTERED UNLESS MEB STATUS ENTERED	AT7C
1452	A PATIENT MUST HAVE A PRIOR MEB STATUS TO BE RESOLVED	AT7C
		ATC
1453	DATE MEB CANDIDATE CONFIRMED MUST BE ENTERED	AT7C
1454	DATE CONFIRMED NOT ALLOWED FOR THIS MEB STATUS	AT7C
1455	DATE CONFIRMED MUST BE AFTER DATE IDENTIFIED	AT7C
1456	DATE MEB CANDIDATE RESOLVED MUST BE ENTERED	AT7C
1457	WARD DATE/TIME MUST BE AFTER PREVIOUS ABSENT STATUS DATE/TIME	ATCO
1458	DATE RESOLVED MUST BE AFTER DATE CONFIRMED	AT7C
1459	INITIAL ADMISSION MTF MUST BE ENTERED ON A TRANSFER	AT2C
1460	DATE OF INITIAL ADMISSION MUST BE ENTERED ON A TRANSFER	AT2C
1461	THE DATE A PATIENT WAS TRANSFERRED IN CANNOT BE AFTER THE DATE OF ADMISSION	AT2C
		CMADC

MESSAGE CODE	MESSAGE	PROGRAM NAME
1462	CLINICAL SERVICE MUST BE CARD-FOR-RECORD	AT2C
1463	MUST ENTER CASUALTY STATUS TO ENTER CASUALTY DATA	AT6C
1464	MUST HAVE PRIOR CASUALTY STATUS TO BE REMOVED FROM ROSTER	AT6C
1465	MUST ENTER CASUALTY DIAGNOSIS AND PROGNOSIS	AT6C
1466	DATE REMOVED NOT ALLOWED FOR THIS CASUALTY STATUS	AT6C
1467	DATE REMOVED FROM CASUALTY STATUS MUST BE AFTER DATE PLACED ON IT	AT6C
1468	AUTHORIZING PHYSICIAN AND REASON MUST BE ENTERED TO PROCESS CANCELLATION	AT8C
1469	IF CAUSE OF INJURY TEXT AND CODE ARE BLANK, ON-DUTY FLAG MUST BE BLANK	AT4C
1470	IF CAUSE OF INJURY CODE AND TEXT ENTERED, ON-DUTY FLAG MUST BE ENTERED	AT4C
1471	MUST ENTER DATE/TIME WHEN WARD CHANGES	ATCO DSXC
1472	ABSENT STATUS DATE/TIME MUST AGREE WITH WARD DATE/TIME	AT5C
1473	MUST ENTER ATTEND PHYSICIAN DATE WITH ATTEND PHYSICIAN	ATCO
1474	INITIAL CLINICAL SERVICE DATE/TIME MUST BE THE SAME AS DATE/TIME ADMISSION	ATCO
1475	INITIAL ABSENT STATUS DATE/TIME MUST BE THE SAME AS DATE/TIME ADMISSION	ATCO
1476	INITIAL WARD DATE/TIME MUST BE THE SAME AS DATE/TIME ADMISSION	ATCO
1477	CAN'T USE FUTURE ADMISSION DATE EXCEPT FOR PRE-ADMIT	ATCO
1478	MUST ENTER TIME FOR ADMISSION DATE/TIME EXCEPT FOR PRE-ADMIT	ATCO CMADC
1479	CAN'T USE FUTURE ATTENDING PHYSICIAN DATE ASSIGNED EXCEPT FOR PRE-ADMIT	ATCO
1480	CAN'T ENTER FUTURE CLINICAL SVC DATE EXCEPT FOR PRE-ADMIT	ATCO
1481	CAN'T ENTER FUTURE WARD DATE EXCEPT FOR PRE-ADMIT	ATCO
1482	MUST ENTER TIME FOR CLINICAL SVC DATE/TIME EXCEPT FOR PRE-ADMIT	ATCO
1483	MUST ENTER TIME FOR EFFECTIVE DATE/TIME EXCEPT PRE-ADMIT	AT5C
1484	CAN'T ENTER FUTURE DATE FOR EFFECTIVE DATE/TIME EXCEPT FOR PREADMIT	AT5C
1485	CAN'T ENTER FUTURE DATE FOR DATE IDENTIFIED, EXCEPT FOR PRE-ADMIT	AT7C
1486	TRANSFER-IN DATA CANNOT BE ENTERED IF SOURCE OF ADMISSION IS NOT TRANSFER	AT2C CMADC
1487	CAN'T ENTER DATE RESOLVED IF MEB CANDIDATE IS NOT RESOLVED	AT7C
1488	MOTHER'S ABSENT STATUS MUST INDICATE SHE IS PHYSICALLY 'IN' THE MTF.	AT1C
1489	ADMITTING PATIENT SAME DAY AS PATIENT'S LAST DISPOSITION	ATC2
1490	CAN'T ENTER WARD DATE WITHOUT WARD TIME	ATCO
1491	REGISTER NUMBER MUST BE ENTERED IF PATIENT IS NOT A PRE-ADMIT	ATCO
1492	WHEN CLINICAL SERVICE IS CHANGED, DATE & TIME MUST BE ENTERED	ATCO
1493	NEW CLIN SERVICE DATE MUST BE AFTER OLD CLIN SERVICE DATE	ATCO
1494	PATIENT CANNOT BE SUBSISTING ELSEWHERE WITHIN 24 HOURS OF ADMISSION	AT5C
1495	ONLY ONE CONVALESCENT LEAVE ALLOWED PER HOSPITALIZATION	AT5C
1496	ADMISSION DATE CANNOT BE EARLIER THAN DATE OF BIRTH	ATCO CMADC
1497	FOR NEWBORNS, DATE OF BIRTH MUST BE EQUAL TO THE ADMISSION DATE	ATCO
1498	THE CLINICAL SERVICE CANNOT BE CHANGED TO QUARTERS (AJA OR AJD)	ATC
1500	HISTORY AND EVENTS FILE IS NOT AVAILABLE, PLEASE WAIT!	
1501	ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE	ATFIL2 NBPFIL
1502	ABSENT STATUS CHANGE TO STATUS IN ON OTHER THAN EFFECTIVE DATE	ATFIL2
1503	WARD CHANGED ON DATE OTHER THAN EFFECTIVE DATE	ATFIL2
1504	ADMISSION CANCELLED ON OTHER THAN ADMISSION DATE	ATFIL2
1505	EVENT RECORD FOR INITIAL ADMISSION WAS NOT GENERATED	
1506	ABSENT STATUS CHANGE TO STATUS OUT ON OTHER THAN EFFECTIVE DATE	ATFIL2
1507	ADMISSION CANCELLED TO PREADMISSION ON OTHER THAT ADMISSION DATE	ATFIL2
1600	TABLE CODE ALREADY EXISTS	SYMCOM
1601	TABLE CODE DOES NOT EXIST	SYMCOM
1602	TABLE NOT VALID FOR OPTION SELECTED	SYTM
1603	ENTRY MUST BE NUMERIC	SYTM1
1604	Can't delete code before it is added	SYU
1605	Can't change code that has not yet been added	SYTM1
1606	FIELD HAS WRONG NUMBER OF DECIMAL PLACES	SYTM1
1607	TRAINING FLAG MUST BE SET TO 'Y' WHEN TUTORIAL FLAG IS 'Y'	SYUC

MESSAGE CODE	MESSAGE	PROGRAM NAME
1703	DISPOSITIONED PATIENT MUST HAVE TYPE AND DATE/TIME	CMADC
1704	DISPOSITION TYPE IS INCONSISTENT WITH PATIENT CATEGORY	DSC
1705	DEATH DISP TYPE CAN NOT HAVE DISP DATE GREATER THAN CURRENT DATE	DSC
1706	DISPOSITION TYPE NOT TRANSFER - CAN NOT ENTER MTF	DSC
		CMADC
1707	MTF TRANSFERRED MUST BE ENTERED	DSC
1708	DISPOSITION TIME MUST BE ENTERED	DSC
1709	PHYSICIAN ORDERING DISPOSITION REQUIRED	DSC
1710	DISPOSITION DATE/TIME CAN NOT BE LESS THAN ADMISSION DATE/TIME	DSC
1711	DISP DATE/TIME CAN NOT BE GREATER THAN CURRENT DATE/TIME	DSC
1712	ADMISSION AND DISPOSITION DATE/TIME MUST BE EQUAL FOR CRO/ERD	DSC
1713	DISPOSITION TYPE NOT VALID FOR NEWBORN	DSC
1714	RETAINED DISP DATE/TIME MUST BE GREATER THAN MOTHER'S DISP DATE/TIME	DSC
1715	DISPOSITION DATE MUST EQUAL ADMISSION DATE FOR SAME DAY DISPOSITION	DSC
1716	DISPOSITION DATE/TIME CAN NOT EQUAL THE ADMISSION DATE/TIME	DSC
1717	DISP DATE/TIME MUST BE GREATER THAN LAST ABS STA DATE/TIME	DSC
1718	DISP DATE/TIME MUST BE GREATER THAN LAST CLN SVC DATE/TIME	DSC
1719	CAN NOT DISPOSITION PATIENT FROM CURRENT ABSENT STATUS	
1720	ENTRY MUST BE A NEWBORN PAY STATUS	NBPC
1721	CANCEL DISPOSITION NOT ALLOWED FOR NON-DISPOSITIONED PATIENT	DSX
1722	WARD AND WARD DATE/TIME MUST BOTH BE CHANGED OR BOTH LEFT AS IS	DSXC
1724	WARD CAN BE ENTERED FOR INPATIENT ABSENT STATUS ONLY	DSXC
1725	WARD MUST BE ENTERED FOR INPATIENT ABSENT STATUS	DSXC
1726	DISPOSITION TYPE ONLY VALID FOR NEWBORNS	DSC
1727	CRO ADMISSION MUST HAVE A DISPOSITION TYPE OF CRO	DSC
1790	DISPOSITION ENTERED ON OTHER THAN CURRENT DATE	
1791	DISPOSITION CANCELLED ON DATE OTHER THAN DISPOSITION DATE	
1792	MOTHER IS NOT AN INPATIENT - PLEASE ENTER RETAINED SOURCE OF ADMISSION	
1793	CHANGED FROM RETAINED/PAY STATUS TO NEWBORN DUE TO MOTHER'S DISP CANCEL	NBX
1910	PROCEDURE DATE MUST BE ENTERED	
1911	PRIMARY PROVIDER MUST BE ENTERED	
1912	PROCEDURE DATE MUST BE DURING HOSPITAL STAY	
1913	FIRST PROCEDURE DATE MUST NOT BE GREATER THAN SECOND PROCEDURE DATE	
1914	MUST NOT ENTER PROVIDER NAME FOR PROCEDURES NOT PERFORMED IN THIS HOSPITAL	
1915	DATE OUTSIDE HOSPITAL STAY - IF TRANSFER-IN MAY WISH TO CODE PROCEDURE 'U'	CR188C
1916	????	
1917	DATE PROVIDER PERFORMED PROCEDURE WAS PRIOR TO DATE ASSIGNED TO HOSPITAL	
1918	PROVIDER PROFILE NOT YET BUILT	
1920	PROCEDURE DATE MUST BE ENTERED	
1921	ATTENDING/PRIMARY PROVIDER MUST BE ENTERED	CR183C
1922	PROCEDURE DATE MUST BE DURING HOSPITAL STAY	
1923	FIRST PROCEDURE DATE MUST NOT BE GREATER THAN SECOND PROCEDURE DATE	
1924	MUST NOT ENTER PROVIDER NAME FOR PROCEDURES NOT PERFORMED IN THIS HOSPITAL	
1925	DATE OUTSIDE HOSPITAL STAY - IF TRANSFER-IN MAY WISH TO CODE PROCEDURE 'U'	CR188C
1926	????	
1927	DATE PROVIDER PERFORMED PROCEDURE WAS PRIOR TO DATE ASSIGNED TO HOSPITAL	
1928	PROVIDER PROFILE NOT YET BUILT	
1930	PROCEDURE DATE MUST BE ENTERED	
1931	PRIMARY PROVIDER MUST BE ENTERED	
1932	PROCEDURE DATE MUST BE DURING HOSPITAL STAY	
1933	FIRST PROCEDURE DATE MUST NOT BE GREATER THAN SECOND PROCEDURE DATE	
1934	MUST NOT ENTER PROVIDER NAME FOR PROCEDURES NOT PERFORMED IN THIS HOSPITAL	
1935	DATE OUTSIDE HOSPITAL STAY - IF TRANSFER-IN MAY WISH TO CODE PROCEDURE 'U'	
1936	????	
1937	DATE PROVIDER PERFORMED PROCEDURE WAS PRIOR TO DATE ASSIGNED TO HOSPITAL	
1938	PROVIDER PROFILE NOT YET BUILT	
1940	PROVIDER WAS NOT ASSIGNED TO HOSPITAL WHEN PATIENT WAS DISCHARGED	CR183C
		QASAC

MESSAGE CODE	MESSAGE	PROGRAM NAME
1941	PROVIDER'S PROFILE IS NOT ESTABLISHED - CONTACT QUALITY ASSURANCE	CR183C
		QASAC
		CPBPC
		CR198C
		QAEC
1950	ADMISSION DATE MUST BE ENTERED	CR186C
1951	DISPOSITION DATE MUST BE ENTERED	CR186C
1952	DISPOSITION DATE CAN NOT BE LESS THAN ADMISSION DATE	CR186C
1953	ADMISSION DATE CAN NOT BE LESS THAN PREVIOUS DISPOSITION DATE	CR186C
1954	DISPOSITION DATE CAN NOT BE GREATER THAN NEXT ADMISSION DATE	CR186C
1955	NUMBER OF DAYS TOTALED MUST EQUAL DAYS IN THIS MTF	CR186C
1956	MTF CODE MUST BE ENTERED FOR EACH MTF IN THE TRANSFER HISTORY	CR186C
1957	TRANSFER HISTORY DATA NOT ALLOWED - PATIENT IS NOT TRANSFER IN	CR186C
1960	CAUSE OF DEATH/SEPARATION MUST HAVE CORRESPONDING DIAGNOSIS	CRFC
1961	RECORD TRACKING STATUS MUST BE CODED BEFORE STORING RECORD - SELECTION 9	CRFC
1962	TRANSFER-IN PATIENTS MUST HAVE TRANSFER HISTORY DAYS (4)	CRFC
1963	ATTENDING/PRIMARY PROVIDER MUST BE ENTERED ON MISCELLANEOUS SCREEN	CRFC
1964	NON-PROCEDURAL PROVIDER ALSO LISTED AS A PROCEDURAL OR PRIMARY PROVIDER	CRFC
1970	FIRST DIAGNOSIS ENTRY MUST HAVE A CODE	CR184C
1971	ONLY TEXT FIELDS ALLOWED WHEN NO DIAGNOSIS CODE ENTERED	CR184C
1996	MOTHER'S RECORD IN USE	AT1C
		CM
1997	PATIENT NOT CURRENTLY ADMITTED	
1998	NO INPATIENT EPISODES TO DISPLAY FOR THIS PATIENT	
1999	NO INPATIENT EPISODE SELECTED	
2000	NO PATIENT SELECTED	RGC2
2001	NEW PATIENT HAS SAME SSN-FMP AS AN EXISTING PATIENT	RG
		RGC2
2002	PATIENT IN USE	RGC2
2003	FAMILY IN USE	RG
		RGSSN
2004	PATIENT NOT ON FILE	
2005	SYSTEM PROBLEM-CALL SYSTEM MANAGER	RG
		RGSSN
2006	MUST ENTER ALL FIELDS ON A NEW PATIENT	
2007	INVALID SELECTION ENTERED	
2008	EPISODE NUMBER NOT ON FILE	PTLKP
		PTESLK
2009	PATIENT NAME MUST BE ENTERED LAST NAME COMMA FIRST NAME	PT
2010	TRANSFER FUNCTION NOT ALLOWED - PATIENT NOT CURRENTLY ADMITTED	AT
2011	REGISTER NUMBER FILE IS IN USE, PLEASE WAIT!	AT
		ATLOAD
		ATRW
		SYRB
		SYRR
2012	PATIENT IS ALREADY ON FILE WITH THIS SSN-FMP.	RGSSN
2013	CAN'T DISPLAY HISTORY FOR A NEW PATIENT	
2014	TIME MUST BE ENTERED WITH DATE FOR WARD DATE/TIME FIELD	ATC
2015	LAST EPISODE ALREADY DISPLAYED	
2016	EARLIEST EPISODE ALREADY DISPLAYED	
2017	DATE OF BIRTH MAY NOT BE A FUTURE OR IMPRECISE DATE FOR A NEW PATIENT	PT
2018	USED BLOCK NUMBER	
2019	OVERRIDE REGISTER NUMBER IS NOT IN BLOCK OF NUMBERS FOR MANUAL ASSIGNMENT	ATRW
2020	NO AVAILABLE BEDS ON WARD	ATRW
		CM
2021	WARD STATUS RECORD NOT AVAILABLE, PLEASE WAIT!	ATRW
		CM
2022	REGISTER NUMBER IN USE	ATRW

MESSAGE CODE	MESSAGE	PROGRAM NAME
2023	CAN'T EDIT SSN OF SPONSOR WITH DEPENDENTS(EDIT DEPENDENT-REENTER SPONSOR)	RGSSN RGFMP
2024	NAME MUST NOT CONTAIN NUMBERS	NAMED
2050	CLINICAL RECORDS CANNOT BE PROCESSED FOR THIS PATIENT	CR
2051	INVALID REGISTER NUMBER	CR
2052	PATIENT'S RECORD IN USE BY ANOTHER CLINICAL RECORDS PROCESS	CR
3000	ENTRY NOT IN TABLE	
3020	BLOCK DOES NOT EXIST	SYRR
3021	BLOCK ALREADY EXISTS	SYRB
4000	ACTION AND CURRENT RECORD STATUS ARE INCONSISTENT	CRACT
4001	THIS USER CODE IS NOT ON FILE	CRACT
4002	THIS USER CODE IS NOT VALID FOR SUPERVISOR ACTIONS	CRACT
4003	INVALID ACTION	CRACT
4004	MAY ONLY DELETE CORRECTED RECORDS	CRACT
4007	USE DELETE SELECTION TO DELETE AN ENTRY	CRSEL
4008	INVALID SELECTION	CRSEL
4009	INVALID SELECTION FOR STATUS	CRSEL
4010	DATE COMPLETE MUST NOT BE EARLIER THAN START DATE.	CR198C
4011	IF DATE COMPLETE IS ENTERED, ASSOCIATED MISSING FIELD MUST ALSO BE ENTERED	CR198C
4012	DATE COMP DICT MUST BE EARLIER THAN OR EQUAL TO DATE COMP SIG	CR198C
4013	IF ANY ONE OF THE 4 MISSING FLDS IS ENTERED, PROVIDER MUST BE ENTERED	CR198C
4014	IF DATE COMPLETE IS ENTERED, PROVIDER MUST ALSO BE ENTERED	CR198C
4015	START DATE CANNOT BE EARLIER THAN DISPOSITION DATE	CR198C
4016	SUSPENSE DATE CANNOT BE EARLIER THAN PROVIDER'S ASSIGNMENT DATE TO MTF	CR198C
4017	INVALID RECORD STATUS, RECORD HAS BEEN COMPLETED	CR198C
4018	INVALID RECORD STATUS, RECORD IS NOT YET COMPLETED	CR198C
6000	QUESTION #1 CANNOT BE CHANGED FROM SYSTEM DEFAULT 'Y'	QAEC
6002	INVALID INCIDENT NUMBER	QAI
6003	INVALID PROBLEM NUMBER	QAP
6004	EMERGENCY ROOM LOG NUMBER MUST BE ENTERED	QAEC
6005	EMERGENCY ROOM LOG NUMBER MAY NOT BE CHANGED ON AN EXISTING RECORD	QAEC
6006	EMERGENCY ROOM LOG NUMBER ALREADY IN USE	QAEC
6010	INPATIENT INCIDENT PERSONNEL MUST HAVE REGISTER NUMBER	QAIC QAPIC
6011	THERE ARE NO Y ANSWERS - NO AUDIT PERFORMED	QASA
6012	FOR QUESTION 3,6,8,11,14,18, CANNOT CHANGE TO 'N' WHEN CR INDICATED 'Y'	QAEC
6013	IF PROVIDER IS ENTERED, QTY MUST ALSO BE ENTERED	CPBPC
6014	IF PROVIDER IS ENTERED, DATE MUST ALSO BE ENTERED	CPBPC
6015	EFFECTIVE DATE CANNOT BE A FUTURE DATE OR EARLIER THAN 3 YEARS AGO	CPBPC
6016	NO MORE RECORDS	CPNX
6019	YEAR ENTERED CANNOT BE OLDER THAN THE OLDEST EXISTING YEAR BUCKET	CPBPC
6020	QUESTION NUMBER IS NOT A VALID MTF QUESTION NUMBER	QAQLKP
6021	QUESTION NUMBER IS NOT THE NEXT UNSPECIFIED QUESTION	QAQLKP
6023	IF PROVIDER IS BLANK, QTY AND EFF DATE CANNOT BE ENTERED	CPBPC
6024	IF PROVIDER IS BLANK, ASSOCIATED EFF DATE FILED MUST ALSO BE BLANK	CPBPC
6025	NEW STATUS DATE CANNOT BE EARLIER THAN EXISTING STATUS DATE	QAPIC
6026	CANNOT CHANGE STATUS DATE OF THE PAST STATUS HISTORY	QAPIC
6028	EFFECTIVE DATE CANNOT BE EARLIER THAN PROVIDER'S ASSIGN DATE TO THIS MTF	CPBPC
6030	MUST SPECIFY PROVIDER WHEN ACTION CODE IS SET INDICATING POST TO PROVIDER	QASAC
6031	MAY NOT ENTER PROVIDER UNLESS ACTION CODE SPECIFIES POSTING TO PROVIDER	QASAC
6032	PROVIDER PROFILE IN USE	CPP
6033	QA IE CODE IS A DUPLICATE - NOTE CODE AND CONTACT SYSTEM MANAGER.	CPP
6034	QA OCCURRENCE SCREENING IN USE.	QAQ
6035	MTF SPECIFIC QUESTIONS MAY NOT BE POSTED TO PROVIDER PROFILE	QASAC
6036	MTF OCCURRENCE SCREENING QUESTION(S) MUST BE ANSWERED	QAMC
6037	ALL QUESTIONS ANSWERED NEGATIVE. ENTER Y IF THIS IS CORRECT:	QAO QAE
6038	INPATIENT OCCURRENCE SCREENING RECORD IN USE AT ANOTHER TERMINAL	QAO

MESSAGE CODE	MESSAGE	PROGRAM NAME
6039	PROBLEM OR INCIDENT LOG NUMBER IN USE AT ANOTHER TERMINAL	QAPI
6040	PROVIDER FILE IS IN USE AT ANOTHER TERMINAL	QADEL
6041	CANNOT ADD/DELETE MISSING SIG/MISSING DICT/PROVIDER TO A DELINQUENT RECORD	CR198C
6042	CANNOT CHANGE DATE COMPLETED OF A DELIQUENT RECORD	CR198C
6043	CANNOT CHANGE RECORD TRACK START DATE OF A DELIQUENT RECORD	CR198C
6044	6 CHARACTER PROVIDER ID MISSING - CONTACT SYSTEM MANAGER.	CPP
6045	DUPLICATE AF PROVIDER ID - CONTACT SYSTEM MANAGER.	CPP
6048	CANNOT PROCESS CHECKLIST FOR QUARTER PATIENT	QAO
9000	VARIABLE FIELD ID MUST BE 'V' FOLLOWED BY NUMBER	RPVE
9002	INVALID REPORT NUMBER ENTERED	RPR
9003	REPORTS MUST BE SELECTED IN ASCENDING ORDER	RPR
9004	NO PREVIOUS PAGE	RPR SYTL
9005	NO NEXT PAGE	RPR SYTL
9006	CAN NOT PICK NIGHTLY REPORTS BY NUMBER AND 'N' AT THE SAME TIME	RPR
9007	CAN NOT PICK MONTHLY REPORTS BY NUMBER AND 'M' AT THE SAME TIME	RPR
9008	REPRINT NOT VALID OR NO PRIOR INFORMATION STORED FOR THIS REPORT	RPOPE
9100	INVALID FILE REFERENCE	RPDDE
9101	CDT, CTM, V, AND T FIELD NAMES CAN NOT HAVE A FILE REFERENCE	RPDDE
9102	FIELD NUMBER MUST HAVE A FILE REFERENCE	RPDDE
9103	T AND V MUST BE FOLLOWED BY A NUMBER GREATER THAN ZERO	RPAEC RPDDE
9104	INVALID FIELD NUMBER FOR FILE REFERENCE	RPAEC
9105	ONE COMPUTED VARIABLE CAN NOT FORWARD REFERENCE TO ANOTHER COMPUTED VARIABLE	RPDDE
9106	COMPUTED VARIABLE CAN NOT REFERENCE ITSELF	RPDDE
9107	OVERRIDE TRANSFORM FLAG MUST BE Y OR NOT ENTERED	RPAEC
9108	TRANSFORM MUST BE EITHER A LINE OF MUMPS CODE OR A PREPARED TRANSFORM NAME	RPAEC RPOTCE
9109	INCORRECT NUMBER OF ARGUMENTS ENTERED FOR TRANSFORM	RPOTCE
9110	INVALID QUALIFIER ENTERED	RPLVE
9111	FILE AND/OR FIELD REFERENCE MUST BE ENTERED FOR ALL EXISTING ENTRIES	RPFC
9112	SELECTION ENTRIES MUST HAVE A FILE REFERENCE	RPFC
9113	SELECTION ENTRY MUST HAVE LOW LOGIC VALUE	RPFC
9114	'FAKE' ONLY ALLOWED FOR PICTURE FIELD DEFINITIONS	RPDDE
9115	'FAKE' CAN NOT HAVE A FILE REFERENCE	RPDDE
9120	h AND t ONLY ALLOWED IN FIRST COLUMN	RPFS
9121	CAN NOT USE A REPEAT NUMBER GREATER THAN 79	RPFS
9122	TRAILER LINES CAN ONLY HAVE f AND p FIELDS	RPFS
9123	INVALID CHARACTER	RPFS SGFS
9124	REPORT MUST HAVE AT LEAST ONE DETAIL LINE	RPFS